IN THE CORONERS COURT)
AT CANBERRA IN THE) **CD 175/08**
AUSTRALIAN CAPITAL TERRITORY)

INQUEST INTO THE DEATH OF
TANIA PAULINE LIOULIOS
née CHACOS

Findings of Coroner Grant Lalor
Delivered on the 27th Day of March 2009

1. On 12 July 2008 I was advised as a Coroner that Mrs Tania Pauline Lioulios died at Calvary Hospital as a result of injuries sustained whilst being held in custody. This custody was imposed as a result of her refusal to sign a bail undertaking in proceedings before the Australian Capital Territory Magistrates Court ("the Court") on 4 July 2008. The injuries were sustained as the deceased was being transported by officers from ACT Corrective Services ("Correctives") from the Court cells to the Belconnen Remand Centre ("BRC").

2. On 17 July 2008 I was notified by the Executive Director of Corrective Services, Mr James Ryan AM, of the death as a death in custody. The *Coroners Act 1997* ("the Act") casts an obligation, punishable as a criminal offence, if a custodial officer fails to report a death in custody known to him to the Coroner if he has reasonable grounds to believe that such death has not been so reported.

3. The Act sets out the responsibilities of the Coroner relating to deaths in the Australian Capital Territory and of residents of this Territory. Section 13 of that Act sets out mandatory provisions relating to the holding of an inquest by a Coroner. This inquest relates to the *"manner and cause of death of a person"* made concerning a *"death in custody".*

4. Section 14 provides a discretion in a Coroner not to hold a hearing in relation to a death in certain stipulated circumstances. Special legislative provisions are made concerning a *"death in custody".*

5. The term *"death in custody"* is defined in section 3C of the Act insofar as is apposite in this matter as

*(1) For this Act, **death in custody** means the death of a person—*

(1)…

(i) while in, being taken into, or after being taken into, the custody of a custodial officer; …

6. Subsection (2) of section 3C provides that a death that occurs *"because of a fatal injury sustained in a place, or in circumstances, mentioned in subsection (1)"* is a death in custody.

7. A Correctives Officer is a *"custodial officer"* for the purposes of the Act (section 3D). The *Legislation Act 2001* in Part 1 of the dictionary provides that a *"Correctives officer means a Correctives officer under the* Correctives Management Act 2007*".* Section 19 of that Act provides that the Chief Executive *"may appoint a public servant, or anyone else, as a Correctives officer for this Act."* It is not disputed that at the time of sustaining the fatal injuries on 4 July 2008 the deceased was in the lawful custody of a custodial officer.

8. The Act in section 14 specifically excludes a death in custody from the statutorily provided discretion not to conduct a hearing by a Coroner in such circumstances.

9. The general requirements relating to a Coroner's findings in an inquest are to be found in section 52 of the Act which provides

(1) A coroner holding an inquest must find, if possible -
(a) the identity of the deceased; and
(b) when and where the death happened; and
(c) the manner and cause of death; and
(d) in the case of the suspected death of a person - that the person has died.

(2) A coroner holding an inquiry must find, if possible -
(a) the cause and origin of the fire or disaster; and
(b) the circumstances in which the fire or disaster happened.

(3) At the conclusion of an inquest or inquiry, the coroner must record his or her findings in writing.

(4) A coroner may comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice.

10. Section 55 provides that where a Coroner is to include in a finding or report any comment adverse to a person identifiable in that report he must give the person a copy of the proposed comment and a written notice that

such person may within a defined time make a submission to the Coroner or give him a written statement concerning the proposed comment.

11. Part 6 of the Act specifies additional provisions relating to deaths in custody.

12. Pursuant to section 63 of the Act, on 15 July 2008 I wrote to the Chief Police Officer for the ACT and requested the assistance of police officers in the investigation for an inquest in this matter. By letter dated 25 July 2008 Senior Constable Sally Nayda was allocated as case officer for this matter.

13. On 15 July 2008 I granted permission to the deceased's sister, at her request, to be present at the post mortem (section 70 of the Act).

14. Section 39 of the Act empowers a Coroner to exercise a discretion to appoint a lawyer to assist for an inquest in relation to a death, other than a death in custody. Section 72 of the Act removes any discretion in a Coroner in relation to a death in custody and a lawyer must be so appointed. By instrument I appointed Gregory Alan Stretton to assist me in relation to this inquest.

15. This appointment caused disquiet in some circles as it was felt that a lawyer from within the Office of the Director of Public Prosecutions for the ACT ("the DPP") should have been so appointed. The Director, or his nominee, has been appointed generally pursuant to section 39 of the Act with the residual option in an individual Coroner to appoint otherwise in specific matters.

16. The appointment in this matter was made so as to avoid any perception of bias in this hearing. The Director of Public Prosecutions is an independent statutory office holder who is tasked by the legislature with instituting and carrying on prosecutions on behalf of the community of the Australian Capital Territory. In this case there was a possibility that the evidence may have led to my having reasonable grounds for believing that a person or persons may have committed an indictable offence. It seemed to me that if such a situation arose it could be said that a member of the DPP should not be assisting the Coroner.

17. Further, section 74 of the Act requires a Coroner to include in the record of proceedings findings *"about the quality of the case, treatment and supervision of the deceased that, in the opinion of the Coroner contributed to the cause of death"*. The general jurisdiction of the Coroner (section 52(4)) also includes a power to comment on any matter *"connected with the death including public health or safety or the administration of justice"*.

18. In the present matter, it seemed that there was a likelihood of comment concerning the passing of information from agencies, including Health, Mental Health, Correctives, the Australian Federal Police ("the AFP") and the Court, to the independent statutory prosecuting authority so that he might be fully apprised of all matters relevant to his decision to prosecute.

BACKGROUND INFORMATION

19. Tania Pauline Lioulios née Chacos was born in Queanbeyan on [redacted] 1965 to Chris and Annette Chacos and was the second of five children. In 1988 she met Dimitris Lioulios in Greece and they married, returning to Australia in 1989. There are two daughters of the marriage.

20. Mrs Lioulios was a successful self employed psychologist and had a private practice located in the Deakin Specialist Centre.

21. In about January 2007, Mrs Lioulios separated from her husband and commenced a relationship with Dr Hugh Veness. Mrs Lioulios had previously had a professional relationship with Dr Veness as they shared several clients and took part in a Peer Review Group together, along with other psychiatrists and psychologists. Mrs Lioulios resided with Dr Veness for a brief period until she purchased a house in Ferrier Place, Kambah in the Gleneagles Estate.

22. In approximately November 2007, the relationship between Mrs Lioulios and Dr Veness ended. Mr Lioulios subsequently moved in to the house that his wife had purchased during their separation.

23. On 23 November 2007 Mrs Lioulios attended the Court and applied for a Protection Order against Dr Veness and an Interim Protection Order was granted and the application adjourned until 21 December 2007.

24. Mrs Lioulios approached Leigh Nomchong, a psychologist and member of their Peer Review Group, and he agreed to act as mediator at a conference between herself and Dr Veness which was subsequently set for 11 December 2007. The stated purpose for the mediation related to a complaint by Mrs Lioulios concerning allegations against Dr Veness to be submitted to the ACT Medical Board. The Protection Order was amended at her request on 11 December 2007 to allow both parties to the Interim Protection Order to participate in the mediation.

25. The mediation was held at Mr Nomchong's premise. After about 30-40 minutes into the mediation, Mrs Lioulios received a phone call on her mobile phone from her husband, who also spoke with Mr Nomchong. After this phone call the conference ended without resolution.

26. On 21 December 2007 both parties were legally represented and the matter was adjourned for hearing to 26 February 2008 and the Interim Protection Order extended in the same terms as the original Interim Protection Order, i.e. the exceptions to the contact between the parties, both as to distance they were to be apart and the communication between them during attempts at mediation, were removed.

27. An application was lodged by the Solicitor for Mrs Lioulios on 8 February 2008 to amend the orders of 21 December 2007 to allow contact between the parties at mediation or to *"facilitate attempts to settle this application"*. On the same day Dr Veness, through his solicitors, filed a document in the Court consenting to the application to vary the conditions of the Interim Protection Order.

28. On 26 February 2008 Dr Veness, through his solicitor, consented to the making of a Final Protection Order for a period of 24 months in the same terms of the Protection Order of 8 February 2008 without any admissions relating to the allegations contained in the application. The Protection Order was so made.

29. On 1 July 2008 Mrs Lioulios personally completed and filed an application for revocation of the Protection Order of 26 February 2008 upon the grounds that:

> "*There is no longer any threat to my safety and the DVO is having a negative impact on professional practice and patient care".*

30. This application was set down for hearing on 3 July 2008.

31. On 1 July 2008 Dr Veness personally filled in and filed documents requesting an Interim Protection Order against Mrs Lioulios. This Order were not granted and the application was adjourned to 3 July 2008, the same date as Mrs Lioulios' application to revoke the Protection Order she had obtained against Dr Veness.

32. On 1 July 2008 as Melissa Batterham, Dr Veness' receptionist, and the doctor were leaving the court, Miss Batterham saw Mrs Lioulios in the court foyer. She spoke with her for a short time and accompanied her to the car park. Mrs Lioulios assured Miss Batterham that she would not cause an incident and then hugged her and approached the driver's door of Dr Veness' vehicle and knelt down beside Dr Veness who was seated in the vehicle.

33. Mrs Lioulios and Dr Veness spoke for a short time during which Mrs Lioulios apologised to Dr Veness. Dr Veness stated that Mrs Lioulios said to him

"*You will be pleased to know that I am not only revoking this order, but I am going to write to the medical board and tell them that complaint I made against you is untrue and that it was done at a time when I was not in my right mind.*"

34. When she got up to leave she kissed Dr Veness on the lips, stroked the side of his face and said that she loved him, then she walked away. Miss Batterham found this to be quite bizarre and formed the opinion that Mrs Lioulios obviously still had feelings for Dr Veness.

35. On Wednesday 2 July 2008, Mrs Lioulios went to Dr Veness' house to drop off a book to Miss Batterham and had a conversation with Dr Veness for about five minutes. Mrs Lioulios wanted Dr Veness to advise her as to what she should tell the ACT Medical Board concerning the complaint that she had made regarding him. Dr Veness said he told her he could not advise her on what she should say and tried to talk with her about her family, but she did not wish to engage in conversation about other topics and left a short time later.

36. On Thursday 3 July 2008, a conference was held by a Senior Deputy Registrar at the Court. Mrs Lioulios attended in company with her husband. The Senior Deputy Registrar described Mrs Lioulios as completely unemotional, speaking in a monotone and disengaged during the conference. While her husband was present she stated that she did not want to revoke the Protection Order. A short time into the conference she asked her husband to leave the room and then explained that she wanted the Protection Order, where she was the applicant and Dr Veness was the respondent, revoked and that she did not want her husband to be aware of this.

37. She was questioned concerning her reasons for this and asked if there had been any pressure placed on her to make this decision. She replied that it was what she wanted. The Protection Order was subsequently revoked.

38. During the conference Mrs Lioulios consented to the making of the Protection Order that Dr Veness had applied for on 1 July 2008 without any admission as to the accuracy of the allegations contained in the application. The protection Order was made by consent for a period of 24 months. After the conference Mrs Lioulios returned to her practice.

EVENTS OF THE AFTERNOON/EVENING 3 JULY 2008

39. About 1:30pm, Ruth Muggleton, the receptionist for Mrs Lioulios' practice left for her lunch break. Mrs Lioulios was not in the office and the door to

her room was open. When she returned at approximately 2:30pm, she noticed that the door to Mrs Lioulios' room was closed.

40. Ms Muggleton went to her desk and sent Mrs Lioulios an email and received a response from her a short time later. This response prompted her to enter Mrs Lioulios' office, where she observed her sitting at her desk and she appeared very upset, stating that it was due to the court case. At this time a patient arrived in the foyer and sat in the waiting area.

41. Mrs Lioulios stated that she would see this patient and asked for a coffee. Ms Muggleton noticed a bottle of gin and a number of tablets on Mrs Lioulios' desk, approximately one quarter of the bottle of gin had been drunk. Ms Muggleton left to make the coffee and returned a short time later, when she found Mrs Lioulios to be lying over her desk, appearing to be asleep.

42. Ms Muggleton rescheduled the patient for another time and went to check on Mrs Lioulios, who still appeared to be asleep. She attempted to rouse her, without success, and then telephoned Mr Lioulios and informed him of the situation.

43. Mr Lioulios told Ms Muggleton to call Mrs Lioulios' sister, Mrs Katrina Lauro, which she did. About 4:04pm on 3 July 2008, she called ACT Ambulance Service ("ACTAS") requesting it attend at the Deakin Specialist Centre due to a suspected overdose of prescription drugs by Mrs Lioulios.

44. Mrs Lioulios was conveyed to The Canberra Hospital ("TCH"), being treated by paramedics in transit by the insertion of a nasopharyngeal airway and administering intravenous fluids. She was admitted to the Accident and Emergency Department ("A & ED") at about 4:55pm.

45. The Senior Staff Specialist on duty in the hospital's A & ED at the time stated that on admission it was said that the patient had

> *"apparently been under a lot of stress and had alleged to have taken multiple drugs and alcohol between 1:00 and 3:00 on that day. Dr Lioulios was found to be semi-conscious in her office and the ambulance was notified by her colleagues*".

46. The doctor in his statement continued:

> *"On arrival in the Emergency Department, Dr Lioulios was drowsy and was treated as a multi-drug overdose. Her main management included supportive treatment with Oxygen, intravenous fluids and continuous monitoring and observation.*

The plan at that stage was to continue with her neuro-observation and a Psychiatric assessment when she was fully awake.

At 2145 hours I placed Dr Lioulios under Emergency Action as she became more awake and threatened to leave the Emergency Department without being seen by the Psychiatric Team. I had to restrain Dr Lioulios against her will for her own protection and placed her under Emergency Action to be assessed by the Crisis Team prior to discharge.

The Mental Health ACT assessment was carried out by Mrs Jennifer Williams and I was approached by the Crisis Team and informed that they were satisfied that Dr Lioulios was safe to go home with her husband following the Mental Health assessment.

Dr Lioulios was to be followed up in the community by the Crisis Team the following morning.

At 2220 hours on the 3rd of July 2008, I completed the authorisation for the Notification of Involuntary Detention form and have documented that Dr Lioulios was seen by the Crisis Team and was cleared to go home with her husband with a follow up in the community the next morning."

47. Jennifer Kay Williams gave evidence before me. She had, at the time, 40 years of nursing experience. On 4 September last year, Senior Constable Nayda contacted Mental Health ACT and sought to interview Mrs Williams and another employee of the Department, but was unable to do so as both were on leave and not expected to return to work until late October or early November. Neither Mrs Bickmore nor Mrs Williams supplied a statement to the investigating police. They were, of course, not obliged to do so. I was advised by Senior Constable Nayda that both employees had, after apparently consulting with the ACT Government Solicitor, declined to participate in an interview with her. They indicated that they were prepared to respond in writing to any questions the Senior Constable put to them in writing. I note in passing that the ACT Government Solicitor appeared at this inquest hearing to instruct counsel to appear to protect the interests of the Territory which included Mental Health, Health and Correctives.

48. No other person from whom a statement was sought for this inquiry declined to provide one to the investigator. Mrs Bickmore did ultimately provide a statement through the ACT Government Solicitor. It is difficult to understand why, if Mrs Williams received legal advice in relation to her appearing before me at the inquest hearing, she would not be advised to do so. Her evidence was not as clear as it might have been had she

made a statement as to the procedure she followed and the actions she took and the sequence of them and the justification for doing so. Her evidence was within a short compass and would have been easily committed to a statement.

49. Pursuant to section 48 of the Act

> *"(3) A record of evidence made for an inquest or inquiry is not, only because it is such a record, admissible in any court as evidence that a person made the depositions included in the record."*

50. Such a statement as provided can thus only be used, apart from an offence relating to perjury or a like offence, for the purposes of the specific inquest for which it was provided. It must always be kept in mind that an inquest hearing is not conducted in an adversarial manner but is an inquiry seeking the truth as to the cause of death and the facts and circumstances surrounding it. Unfortunately parties forget this from time to time.

51. The deceased was taken to the A & ED at TCH and was seen by the Senior Staff Specialist and after being placed under an emergency order was restrained and taken before Mrs Williams who was on duty in the Mental Health area. She was still being restrained by four wardsmen, one on each arm and one on each leg, to prevent her from leaving before being examined by the Mental Crisis Team.

52. Mrs Williams gave evidence that she quickly became *"therapeutically aligned"* with the patient and she was able to have the restraint removed. Mrs Williams initially said that the restraint had not been released until after her assessment and Mrs Williams had spoken with the doctor. She resiled from this and I took it to mean that the patient had not been released, rather than the restraint, until these actions had been completed.

53. It would seem that on presentation of a patient, a computer generated assessment of that patient's mental condition is available. This seems to have been generated for all patients and all the data required in the pro forma is provided before an interview takes place. The probable risk of suicide is generated by the computer and in this case was assessed as *"high".* As Mrs Williams interviewed the patient further, she relayed the information to the triage nurse who put it into the computer and a new risk was generated as *"moderate".* Mrs Williams was at pains to point out that this generated risk from the information put into the computer was but one of the factors she considered in making her ultimate assessment. Five definite areas were the basis for this assessment, previous suicide attempts, extreme stress, impulsive and/or aggressive tendencies, past or present physical or sexual abuse and prison/custody/legal problems. It is difficult to understand the efficacy of such a document as a tool for

deciding whether a patient is at risk of taking his or her own life and, if so, what the risk is. It seems, although it has not been confirmed, that this system of assessment is no longer in use. I am not apprised of what the replacement system is.

54. Mrs Williams gave evidence that the document she filled in following her interview was the document that showed a moderate risk of the patient committing suicide. The computer generated time shown at the top of the document is *"03/07/2008 22:43:31. Doctor Kumar has signed the requisite documentation for the deceased to leave the hospital at 2220 hours".*

55. Mrs Williams stated that she became aware during the interview that the patient was in fact a psychologist and conceded that Mrs Lioulios might have manipulated the situation to her own benefit and that she had concluded this to be *"to some extent only".*

56. The notes were completed by Mrs Williams some time between 1:00am and 2:00am before she went off duty and noted an overdose the previous year, 2007. When asked whether Mrs Lioulios had fully explained the facts surrounding this incident she said that she had not asked

> *"too much as I didn't want to distress the client further, that's always a risk …* (indistinct)… *that one must work out how much information one asks in any situation. I knew there'd been an affair, I knew that there would be marital disharmony of some nature, that's why it was important for me to see Mrs Lioulios."*

57. Mrs Williams stated that she had considered *"all the variables"* and *"came to clinical decision based on my experience and academic qualifications".* She came to this decision after assessing the patient as a low risk of committing suicide and after receiving a guarantee from her that she would *"go home and be safe"*. She spoke with Mr Lioulios and assessed the relationship as

> *"they were in harmony, yes, I felt after looking at them together, I needed to see them together, that they were harmonious, there was no tension I noted".*

58. She stated that her decision was *"that in the best interests of the client she would go home, she wanted to live, and she was going home with her husband I'd assessed as committed to her care"*. She said that it was her normal procedure to tell people into whose care a patient is entrusted that they should *"keep an eye on this person, that they shouldn't be alone and we'll see you in the morning to – to sort out any problems but don't hesitate to ring at any time"*. No one has given any direct evidence that this was said at the time of discharge.

EVENTS FOLLOWING RELEASE FROM HOSPITAL ON 3 JULY 2008

59. After her release from TCH, Mr Lioulios was to take his wife home. However, when she said that she wanted to go to her office to get her prescribed medication and her vehicle and to go to her sister's to get her mobile telephone, Mr Lioulios acceded to this, telling interviewing officers:

> *"… She went to her sister, and then she wanted to get the car from her Deakin office. But I was afraid to say yes. I was saying* 'No, we'll get it tomorrow' *you know. Because I was worried, first, how is she going to drive herself; and second, if she's going to do something stupid to Veness, like what happened. But she insisted. And I know she had reports to do. She was always – not running late, but she had a lot of work.*
> *And she said* 'I'm going to do reports.' *So when she went out, finally I took her to the car."*

60. Being aware of the conditions of her release from TCH, and recognizing the danger of non adherence to them, her husband did nothing to ensure that she complied with them, apart from endeavouring to telephone her.

61. It is believed that Mrs Lioulios consumed more alcohol and prescription medication while at her office at this time, as Ms Muggleton later pointed out to Police that there was more alcohol missing from the gin bottle than when Mrs Lioulios was first taken to hospital the previous afternoon.

62. About 11:50pm Mrs Lioulios went to her sister's residence in Queanbeyan to pick up her mobile telephone. Her sister said that she was shocked that she had been released from hospital, however, stated that she seemed fine when she visited, although she was only there for a very short time.

63. About 12:00am Mrs Lioulios called Miss Batterham's mobile phone. This call was unanswered.

64. About 12:23am Mrs Lioulios called Mr Lioulios, as he had tried to call her. She said to him that she was at work and wanted to finish some reports. They were due to go on a holiday to Greece in a couple of days and she insisted that she wanted to finish the reports before they went overseas.

65. About 12:45am Mrs Lioulios called Miss Batterham's mobile phone again and she answered the call. She said that Mrs Lioulios stated that she was going to come over as she wanted to see Dr Veness, she also told Miss Batterham that they should call the Police if they wanted. Miss Batterham resided in Dr Veness' residence, being previously, as I understand it, the girlfriend of his son, the relationship having, by this time, ended.

66. Miss Batterham informed Dr Veness of the phone call and of Mrs Lioulios' intention to visit. She also informed him that Mrs Lioulios sounded upset. In her statement she said she did not tell Mrs Lioulios that she should not come over because she sounded upset and she wanted to make sure that she was all right due to her knowledge of Mrs Lioulios' history of drug overdoses.

67. About approximately 1:00am Mrs Lioulios arrived at the home of Dr Veness in Kambah, ACT. She let herself in through the back door into the kitchen area and immediately asked whether the Police had been contacted, stating that she knew she was in breach of the consent Protection Order made the previous morning and wanted Police to be called. When Dr Veness and Miss Batterham informed her that they had not contacted the Police, she reached for the kitchen phone. It was not plugged in properly and she was unable to use it. She went into Dr Veness' office to use the phone there, however, she found it not to be working either. Mrs Lioulios stated to them that she wanted to go to gaol. From the evidence available to me it would seem that there was no real attempt by either Dr Veness or Miss Batterham to discuss whatever problem it was she had or to attempt to dissuade her from calling the Police. It was only very shortly after her arrival that she contacted Police.

68. Mrs Lioulios then walked out of the house. It is believed that Mrs Lioulios went to her car to get her mobile phone. Shortly thereafter, as she walked back inside the house, Dr Veness and Miss Batterham observed her ending a conversation with someone on her mobile phone.

69. At 1:06am a call was received at ACT Police Operations. This call was recorded as standard practice. The caller identified herself as Melissa Batterham and gave details of the location where Mrs Lioulios was in attendance and said she was in breach of a protection order.

70. Call charge records later conducted on Mrs Lioulios' mobile phone show that at 1:06am a call was made from it to 131444, which is the number for ACT Police Operations non emergency line. Based on this information, and other information, it is believed that Mrs Lioulios called Police herself and pretended to be Melissa Batterham.

71. When she came back inside the premises, Mrs Lioulios became very upset and started to cry, she stated that she was sorry for hurting them. Miss Batterham tried to comfort her. Mrs Lioulios then hugged Dr Veness and again apologised to him as she continued to cry.

72. Dr Veness and Miss Batterham sat Mrs Lioulios down with them at the dining room table and tried to talk to her. When Dr Veness offered her a cup of tea or coffee, Mrs Lioulios refused and said that *"marijuana might*

help". This seemed strange to Dr Veness and Miss Batterham as both stated they did not know her to use illicit substances, nor did they use such substances themselves. Dr Veness then gave Mrs Lioulios some tobacco which she smoked.

73. Dr Veness stated that he asked if the reason she was upset had anything to do with her husband and she replied that it had. This would not seem to be an adequate explanation for her behaviour.

74. It was said that she stated that she wanted to go to gaol so that no one would run away from her and she would have people who loved her. She further stated that she wanted to kill herself when she got out of gaol. She called herself a bad person but Dr Veness and Miss Batterham told her she was not.

75. Both Dr Veness and Miss Batterham said although there was a Protection Order in place they did not call the Police or tell Mrs Lioulios to leave as they were concerned for her welfare and wanted to try and help her. They feared if they turned her away she may have tried to harm herself. She also told them that she wanted to go to gaol and would kill herself when she was released.

76. The statements taken from Dr Veness and Miss Batterham contain much innuendo concerning and allegations of misconduct by Mr Lioulios towards his wife and in the statement of Mr Lioulios there were many allegations of personal and professional misconduct by Dr Veness. The maker of each of these statements attributed the conduct of the other as being, if not the catalyst for, then certainly contributing to, the mental state of the deceased at the time of her death.

77. At a Directions Hearing in this matter I indicated that I proposed conducting the hearing on the basis that certain facts concerning her state of mind at the time of her death be accepted without any enquiry as to the cause or perceived cause of her state of mind at the time of her death. I was, and am still, of the view that the legitimacy of her held fears and the perceived causes of her stress at the time of her death were not matters for this hearing.

78. To that end I have not permitted allegations of impropriety in the relationship between the deceased and her husband, or in that between her and Dr Veness, to be canvassed. They each had at some stage taken out court orders against the other and the deceased had complained to the ACT Medical Board concerning Dr Veness' conduct. These are all not matters for this hearing. They may be matters into which other authorities may enquire.

79. Dr Veness was represented at the hearing before me and Counsel sought leave, which was granted, to withdraw from the proceedings following my ruling that certain evidence relating to such matters and allegations were not relevant to my inquiry.

AUSTRALIAN FEDERAL POLICE INVOLVEMENT FROM 4 JULY 2008

80. About 1:12am ACT Police Operations dispatched a Tuggeranong patrol to respond to the call made by Mrs Lioulios. About 1:18am, Constables Peter Hockings and Leo Calimbas arrived at 8 Keeling Place, Kambah. Upon entering the premises, they observed Mrs Lioulios, Dr Veness and Miss Batterham all sitting around the dining table. Miss Batterham got up and let Constables Hockings and Calimbas into the premises. Constable Hockings said that the deceased was *"visibly upset"* and she had been crying. She told Constable Hockings that she was upset because Dr Veness had taken out an order against her and that she had breached that order and wanted to go to gaol. She told the Constable that she was on the premises to hurt Dr Veness because of the order he had taken out against her and that she intended killing herself after she had hurt him. She repeated this threat several times. She stated that she had consumed a glass of gin and taken prescription medication.

81. Constable Hockings arrested Mrs Lioulios for a breach of the Protection Order. He stated that he considered that a summons would not be effective in the circumstances as it was his belief that if he did not take her into custody, she would return to inflict harm on Dr Veness, that she would return to the address and carry out her expressed intention.

82. Due to his concern and belief that Mrs Lioulios was resolute in her intent to self harm, he advised her that he was taking her to TCH to speak with a mental health worker. He said that upon being told of this she became agitated and said that she no longer wished to kill herself but would do her gaol time and kill herself following that. She wanted to be taken to the Watch House. Following a conversation with another of the attending Constables, she agreed to go to the hospital.

83. At 1:42am Constable Hockings informed Police Operations that he had a female in custody and was conveying her to TCH for assessment. Whilst at the hospital and awaiting assessment, Mrs Lioulios told Constable Hockings that she had tried to take her life the previous day and that as a result of that she had been in the care of Mental Health. He then offered to ring her husband to advise him of her being in custody and did so.

84. Constable Hockings' actions were in line with The ACT Policing Practical Guide on Persons in Custody, Section 10 (paragraph 4), which states:

"Where a risk of suicide or self harm is identified in relation to a person in police custody, and the person has not been lodged at the RWH, advice from the Mental Health ACT Crisis Assessment and Treatment Team (CATT) will be sought. This may be in the form of a telephone call, attendance by CATT at the scene of an incident or by transporting the person to The Canberra Hospital for assessment/treatment."

MENTAL HEALTH ACT INVOLVEMENT ON 4 JULY 2008

85. Upon arrival at TCH, Police attended A & ED, it being standard practice for a person to be medically assessed prior to seeing a Mental Health ACT Crisis Assessment and Treatment Team ("CATT") worker.

86. The triage nurse on duty was Registered Nurse Michelle Modderman. Ms Modderman conducted a medical assessment of Mrs Lioulios which included completing a Psychiatric Triage Check sheet.

87. During the assessment, Mrs Lioulios stated that she was serious about committing suicide by hanging once she had paid her debt, but did not state what she had done to warrant this or what she meant by *"paid her debt".*

88. Ms Modderman described Mrs Lioulios as slightly drowsy, teary and smelling of alcohol, being able to articulate well and speak clearly. Mrs Lioulios further stated that *"once she had been to court that she intended to hang herself, if she had to go to jail, she would hang herself after she was released".*

89. Ms Modderman filled in the area on the checklist for recent onset of short term memory loss, as Mrs Lioulios had described to her feelings of being overwhelmed, *"at times felt mentally overloaded and anxious regarding possible detention".*

90. Her vital signs were all within normal limits and her Glasgow Coma Scale was 15, indicating that she was fully orientated and aware of her surroundings and reason for being brought to the A & ED. After this assessment Mrs Lioulios was taken into a psychiatric interview room by a CATT worker.

91. While waiting for Mental Health ACT to arrive, Constable Hockings was talking with Mrs Lioulios and she asked him to contact her husband, as he would be concerned about where she was. Constable Hockings called Mr Lioulios and advised him that Mrs Lioulios had been arrested after she breached the protection order between Dr Veness and herself. During

conversation with Mrs Lioulios at this time Police found her to be alert and responsive to questions.

92. A short time after Mrs Lioulios was medically assessed, Mrs Claire Bickmore from CATT attended. Constable Hockings and Mrs Bickmore had a conversation regarding Mrs Lioulios.

93. Constable Hockings informed Mrs Bickmore that they had a female in custody for contravening a protection order, explaining the circumstances surrounding the offence. Constable Hockings also informed Mrs Bickmore that Mrs Lioulios had expressed to him that she wanted to kill herself after she had done her time in gaol.

94. Mrs Bickmore then assessed Mrs Lioulios. During the assessment Mrs Lioulios told Mrs Bickmore the same thing as she told the Police, that she did not want to kill herself until she had finished her gaol time.

95. Constable Hockings said that at *"some stage"* during the assessment Mrs Bickmore told him that Mrs Lioulios had been in the care of Mental Health ACT the previous day due to her attempting suicide at her place of work.

96. Claire Terese Bickmore gave evidence before me. She is a registered nurse and had been a mental health nurse for about eighteen years, having been employed by ACT Health for that time and employed in her present position with CATT since December 1997. Her role within that team was to interview and assess patients who presented at the A & ED and determine whether the Psychiatrist on call for the evening should be called.

97. She commenced duty on night shift on 3 July 2008 at 11:00pm and shortly after 1:00am, an A & ED nurse approached her and told her that the AFP had presented a woman for assessment and said words to the effect that *"she had been threatening to kill herself*".

98. Mrs Bickmore, at the time of her assessment of Mrs Lioulios, had available to her the notes of Mrs Williams who had formed the view, at approximately 2220 that evening, to release Mrs Lioulios into the care of her husband, following the incident at her office that led to her being taken to TCH by ambulance and restrained until assessed by CATT.

99. Ms Bickmore stated to Police that a CATT worker had spoken with Mrs Lioulios the previous day and Mrs Lioulios later informed Police that she had attempted to overdose on medication the previous day.

100. Mrs Bickmore stated that Mrs Lioulios, when asked whether she was *"going to kill herself",* denied any intention to do so, saying words to the

effect *"I'll go to prison first, then kill myself*". Mrs Bickmore said she gained the impression that the patient wanted to make some sort of a stand or public statement. She said:

> *"Mrs Lioulios repeated that she was not suicidal. She didn't express any feelings of sadness or hopelessness, which are often characteristic of people with suicidal intent. I assessed her body language, tone of voice, posture and eye contact to gain an impression of her mental state. She made good eye contact, her tone of voice was firm and confident, her posture was not slumped. She looked me in the eye and said* 'I'm not going to kill myself'*. I gained the impression that she was confident, and I didn't get any impression that she was lying. I had no reason to think she wasn't being truthful."*

101. Mrs Bickmore in her statement continued:

> *"From the things that Mrs Lioulios told me in the ED in this presentation, I gained the impression that she wanted to go to prison, possibly in order to have some effect on her ex-lover. I thought she clearly wasn't going to kill herself in the immediate future, so could be dealt with in other ways, firstly by appearing before the Court the next morning."*

102. In her evidence before me Mrs Bickmore conceded that she did not consider whether Mrs Lioulios might be released from custody from the Watch House, or by the Court the following morning on bail, and what the ramification of this might be in light of the repeated threat of taking her life when she had *"done her gaol time".* Further, she never considered the fact that she had previously been released from TCH, following the incident the previous evening, into the care and supervision of her husband and that she had failed to remain in that care.

103. Mrs Bickmore was aware that the patient was taking medication for ADHD and that this was prescribed for her by a psychiatrist. She did not inquire, she said, as to whether the patient was suffering from depression nor whether she was being treated by a psychiatrist, psychologist or medical practitioner for any other condition apart from ADHD. Mrs Lioulios was at the time seeking the professional help of both a psychiatrist and a psychologist. She never inquired whether the patient had previously attempted to take her own life, although that was available to her in the hospital notes, and she noted that and considered it in making her decision to discharge the patient to be taken back into Police custody and placed in the Watch House.

104. There is a discrepancy in the amount of medication the patient reported to have taken when she advised on 3 July and that she told Mrs Bickmore on 4 July. The amount reported on 3 July is recorded in documentation

available to Mrs Bickmore. No inquiry was made of the patient concerning this discrepancy.

105. Mrs Bickmore said that she had had a discussion at handover from Mrs Williams on her commencing duty on 3 July and, on that handover, she had been advised that Mrs Lioulios had attended at TCH on 3 July and had had to be restrained and placed on an emergency order, which had subsequently been lifted. Notwithstanding the notes from Mrs Williams showed that the patient had been suffering from depression, there was no discussion of this with her.

106. In cross-examination Mrs Bickmore was unable to say when it was that she had seen the earlier notes from Mrs Williams, after discussing the matter with her. She agreed that the entries of Ms Modderman, who had noted that Mrs Lioulios had a *"serious intent to commit suicide"* and that she had planned to hang herself, were available to her.

107. As a result of her assessment of Mrs Lioulios over approximately 20 minutes, Mrs Bickmore came to the conclusion that she was not suicidal and released her to go to the Watch House in custody.

108. As a result of her release, Constable Hockings took Mrs Lioulios to the Watch House. He left her in the police vehicle with a female Officer whilst he informed the Watch House Sergeant on duty at the time, Sergeant Shakeshaft, of what had transpired. He told her that he had a female in custody who had stated that she was suicidal and intended doing *"her gaol time and then commit suicide".* He advised the Sergeant that the female had been *"cleared by Mental Health"* as fit for Police custody. Sergeant Shakeshaft was not prepared to receive the prisoner into the Watch House because of what she had been told concerning Mrs Lioulios' stated suicidal intent. At the time, Constable Hockings did not inform the Sergeant of the incident the afternoon before.

109. Sergeant Shakeshaft asked if the advice from Mental Health had been provided in writing and, when advised it had not, she suggested that the Constable consider placing the prisoner on an emergency order under Section 37 of the *Mental Health (Treatment and Care) Act 1994* so that she could receive the treatment she thought she required.

110. That Section provides that if a police officer has reasonable grounds for believing

> *"that a person is mentally dysfunctional or mentally ill and has attempted or is likely to attempt-*
>
> *(a) to commit suicide; or*
>
> *(b) to inflict serious harm on himself or herself or another person;*

the police officer may apprehend the person and take him or her to an approved health facility."

111. Where a person is so taken to a health facility, the head of that facility is to detain the person at the facility and may keep him or her in such custody as he or she thinks appropriate. Such a detained person is to be examined by a doctor employed at the facility within four hours of arriving at the facility and, such a doctor having reasonable grounds for believing that such a person is mentally dysfunctional or mentally ill and requires immediate treatment or care and the person has refused to receive that treatment or care, may authorise the involuntary detention of the person for a period not exceeding three days.

112. Constable Hockings in his evidence advised that he did not consider that such an application would have any efficacy as Mrs Lioulios had been assessed by a mental health worker as not being immediately suicidal and, I take it, that a mental health worker and a medical practitioner had earlier in the evening released her following an attempted suicide. The mandatory provisions of the *Mental Health (Treatment and Care) Act* would have no effect as the preliminary question as to whether she was likely to attempt to commit suicide was not able to be answered in the positive.

113. Constable Hockings returned Mrs Lioulios to TCH and again presented her to a triage nurse, Megan Wotton. She said that she was aware that the patient had been at the hospital earlier that night as she had been told so by the registered nurse working with her on triage. She said the Police Officer told her that *"the duty officer in the Watch House feels that Mrs Lioulios is too drowsy to be kept under supervision of police".* She was asked to triage the patient and did so and had nothing further to do with her, being advised later that she had been discharged from the hospital.

114. Mrs Bickmore accepted, without having any clear recollection of any conversation, that when she saw Mrs Lioulios on the second occasion she said *"What are you doing back here?"* and she replied *"The police brought me here because I was going to harm myself"*. She remembers the patient replying that she was not going to self harm until after she had served her gaol time when asked if what the Police had alleged was true.

115. Ms Modderman became aware that Mrs Lioulios had been brought back to the hospital and had a conversation with the Police Officers while they were in attendance.

116. During the second attendance Mrs Lioulios' demeanour had changed, she was noticeably drowsy and sleepy and did not talk very much. Police asked her why she was feeling like this and she stated that she had taken

her medication before they had arrived at the house in Kambah. Mrs Lioulios still, however, had a Glasgow Coma Score of 15, indicating that she was still orientated.

117. Constable Hockings had another conversation with Mrs Bickmore before she spoke with Mrs Lioulios again. Mrs Bickmore reassessed Mrs Lioulios for approximately five minutes. During the second assessment, Police heard Mrs Bickmore ask Mrs Lioulios if she understood that the Watch House was not gaol. Mrs Bickmore again stated that she did not have enough grounds to place her on an involuntary detention order and that she held no concerns that she would self harm at that time.

118. Constable Hockings requested that Mrs Bickmore provide written evidence of her decision. A copy of the report was given to Constable Hockings by Mrs Bickmore; he later attached this report to the mention brief at the Watch House. This report consisted of the hospital notes written up by Mrs Bickmore following the first attendance before her and then had added to it a further report following the second assessment carried out by her. This second entry reads:

> *"Further discussion with police about her mental state. Mrs Lioulios is now drowsy as a result of the medications which she has consumed.*
> *ED nurse has also reviewed her – vital signs are fine, (is 15 on Glasgow coma scale).*
> *Copy of this file note given to police.*
> *Mrs Lioulios has again assured me that she is not going to harm herself in the Watchhouse and knows that she will go before magistrate in Morning –has previously been before magistrate."*

119. This note was signed and the time 3:44am appended.

120. Ms Modderman said she spoke with Mrs Bickmore after Mrs Lioulios had left with the Constables and asked her why she had released Mrs Lioulios back into the custody of Police. The reason Ms Modderman asked this was that she was concerned for Mrs Lioulios and had treated her suicide intent as serious. Mrs Bickmore replied to Ms Modderman that *"they all say that, it is attention seeking"* and *"they don't do it"*. Mrs Bickmore indicated she did not recall having a conversation with Ms Modderman or saying this to her. She did not deny saying it.

121. Mrs Bickmore admitted that she did not advise, but should have advised, a *"forensic consultation liaison worker"* of Mrs Lioulios' plight.

122. Accepting that any assessment of a patient presenting to the Mental Health team at the hospital in the early hours of the morning is difficult and is generally a subjective assessment, this second assessment cannot be

described other than as flawed. Matters that influence me in saying this are that

1. The patient at all times indicated a resolute attempt to take her own life albeit when she had served her gaol time.
2. There had been an attempt to take her life which necessitated hospitalisation the afternoon before.
3. The patient had been released into the care of her husband who had not, for some inexplicable reason, insisted that his wife, who was obviously mentally dysfunctional, remain in his company as was the understanding for her discharge from the hospital.
4. A deliberate and flagrant breach of a Protection Order had been committed, with no given reason to the Mental Health officers and with a persistent demand to be taken into custody.
5. No proper account seems to have been taken of the opinion of an experienced examining triage nurse, Ms Modderman.
6. No proper inquiry seems to have been made as to the reason for the Police declining to accept the patient into the Watch House.
7. No consideration was given to the fact that the patient might have been bailed from the Watch House and she would then not be in custody and her threat of self harm when she was released *"from gaol"* could well have been carried out.
8. Whatever the patient told the assessing nurse was accepted at face value. As she put it in evidence: *"I cannot operate on not believing what people say".*
9. No attempt was made to inquire into the basis for the previous attempt at self harm as recorded in the records available to the Mental Health worker.
10. No contact was made with any appropriate authority to follow up contact with the patient the following day. This was even more imperative given her discharge the previous evening in the circumstances set out above and her subsequent presentation in Police custody, threatening self harm at a future date in circumstances that can only be described as unusual.

123. I recommend that where an agency presents a person in custody for an assessment of his or her mental state more than once in a 24 hour period that patient must be seen by a Psychiatric Registrar.

LODGEMENT AT THE WATCH HOUSE

124. Police took Mrs Lioulios back to the Watch House and told Sergeant Shakeshaft of the outcome of the second mental health assessment and showed her the report provided by Mrs Bickmore. Sergeant Shakeshaft accepted Mrs Lioulios into the Watch House but expressed concerns about her being there after threatening self harm.

125. Mrs Lioulios was then required to participate in the reception process. During this she informed Sergeant Shakeshaft of the following in answer to pro forma questions, which were recorded on the Reception and Lodgement of Detainee Form:
    - she is not an Aboriginal or Torres Strait Islander;
    - she is currently taking prescription medications; Xanax 450mg for Depression, Zoloft 200mg for ADHA and anti inflammatory medication;
    - she had been held in custody two years ago;
    - she overdosed on medication and alcohol about 6 months ago in an attempt to seriously hurt herself;
    - she had consumed one glass of gin that had a light intoxicating affect; and
    - she had not consumed any recreational drugs.

126. Sergeant Shakeshaft noted that Mrs Lioulios was *"very unsteady on her feet, her eyes were half closed and that she appeared to be drowsy or drug affected".*

127. Sergeant Shakeshaft classed her as a *'person at risk'* and placed her in cell 8, which is one of the designated cells in the Watch House for prisoners at risk. She was placed on 15 minute personal observations from Watch House staff.

128. The Watch House Operations Manual in chapter 2.7 (dated 1 January 2008) and the ACT Policing Practical Guide on Persons in Custody both define a person "*At Risk"* as being inter alia:

> *"Any person in custody who has shown any inclination of, or is believed by any person, to be capable of harming themselves or another person."*

129. And further as

> *"Any person in custody with whom there is any cause for concern as to their physical or mental wellbeing;"*

130. The Watch House Operations Manual also provides that

*"'*At Risk' *detainees or detainees in the padded cell will be checked every 15 minutes for first two hours, then no greater than one hour intervals after that."*

131. Cell checks were recorded on the Australian Federal Police computer as follows:

4.34 – Physical check nil problems
4.48 – Physical check nil problems
5.02 – 0500hrs physical check all ok
5.17 – 0515hrs physical check. Apparently asleep and breathing normally
0532hrs Physical check. Apparently asleep and breathing normally
5.41 – 0540hrs Physical check conducted by Const Quinn. All ok
6.04 – Physical check – nil problems
6.22 – Physical cell check. Nil problems
6.43 – Physical check. Nil problems
7.01 – Physical cell check. Nil problems.
7.18 – Physical cell check. Nil problems.
7.38 – Cell check nil problems.
7.54 – Cell check completed – transferred to court.

132. About 5.45am Acting Sergeant Jon Horrocks arrived at the Watch House to commence his shift at 6:00am. He was provided with a briefing by Sergeant Shakeshaft in relation all prisoners and specifically in relation to Mrs Lioulios. Sergeant Shakeshaft handed him the report from Mrs Bickmore. As a result of this briefing, he made his Constables aware that Mrs Lioulios was a person at risk and advised that they were to monitor her regularly.

TRANSFER TO ACT CORRECTIVE SERVICES CUSTODY

133. About 7.30am, the ACT Corrective Services Court Transport Unit ("the CTU") arrived at the Watch House to pick up Mrs Lioulios and three other male prisoners. Custodial Officers Kristy Tracey and Ricky Murphy were the attending officers that morning.

134. The AFP In Custody File (BART File) is prepared by the Watch House Sergeant on duty at the time of the transfer of the prisoners in the cells to the custody of Corrective Services Officers for transfer to the Court cells. It had a photo of the detainee attached to the front. This photo was taken of Mrs Lioulios at induction in the Court cells by Correctives. No explanation was given as to why one was not taken at the Watch House, as required by the Watch House Operations Manual, and attached to the

front of the BART file as is required. Included in the file is the prisoner information cover sheet, the property found on prisoner form, the prisoner history form which includes the person's details, visual assessment of the prisoner, prisoner questionnaire, offences summary, bail details, if applicable, cell check details and visitor details and other notes.

135. The prisoner information cover sheet was clearly marked with the stamps *"PRISONER AT RISK"* and *"FV"*. The stamps are in red ink put on a blue background in large lettering. The prisoner information cover sheet also has the following classifications on it under *"Special Concerns or Risk Factors":*

> *"a) Aboriginal or Torres Strait Islander*
> *b) Prisoner at Risk (At risk from other (i.e. Police Informant, child molester etc)*
> *c) Medical Conditions (May need medical examination, medication, special care)*
> *d) Security Risk (Runner, may attempt escape etc)*
> *e) Violent Tendencies (Violent nature, threatened violence)*
> *f) Depression (Prior history of depression, self injury, suicidal, etc)"*

136. Depression was not stamped on the file, however, the prisoner history that was included in the BART file stated the following information in the Visual Assessment of prisoner and the Prisoner Questionnaire:

> *"- Any signs of suicide? YES - stated that she was going to hurt herself when she finished her jail time.*
> *- Appears to be under the influence of alcohol or drugs? YES - stated that she had taken a quantity of speed, medication for her ADHD and also a glass of gin.*
> *- Are you taking any drugs or medication? YES - Zanex (Depression) Zoloft, ADHT, Anti inflammatory.*
> *- Have you been held in custody before? YES - 2 years ago*
> *- Have you ever tried seriously to hurt yourself? YES - Overdose on meds and alcohol 6 months ago*
> *- How much alcohol have you consumed? YES - 1 Glass Gin*
> *- How would that amount of alcohol usually affect you? YES – Light"*

137. The Memorandum of Understanding between ACT Corrective Services and the Australian Federal Police regarding prisoner transfer, Schedule item 3 a (v) states:

> *"A member of the Watch House will ensure that a formal handover of responsibilities for the detainee or prisoner is conducted prior to the commencement of searches by the CTU."*

138. The Watch House Operations Manual also addresses the release of detainees to the custody of Correctives. Section 2.14 (paragraph 4) states:

> *"A briefing to Correctives on all issues pertaining to detainees will include but is not limited to:*
>
> - *Circumstances resulting in detainee being in Police custody and their behaviour/demeanour at the time of arrest;*
> - *Whether any use of force options were used in affecting the arrest of the detainee and if any decontamination procedures have been undertaken &/or are still needed;*
> - *Detainee welfare, including present demeanour and behaviour, medical status and medication requirements (including reference to any infectious or contagious diseases) and any other pertinent factors; and*
> - *Any rationale behind particular cell allocation for detainees."*

139. On arrival at the Watch House the Custodial Officers, as a practice, review the BART file and record and search any property that belongs to the detainee and compare this against the Police record in case there are discrepancies. When the detainee is brought from the cells, the Custodial Officers then conduct a pat search, place the detainee in handcuffs, then place the him/her in a Correctives' vehicle for transportation to the Court Cells.

140. On this occasion Correctives Officer Tracey viewed the BART file while Officer Murphy searched and recorded the property.

141. Officer Tracey did not recall the prisoner information sheet being stamped with any alerts. Most of the information that they require is contained in the BART file, however, Officer Tracey stated that it was her habit to inquire how the detainees have been throughout the night for the officers' safety when dealing with them. She recalled asking the Watch House Constables how Mrs Lioulios had been throughout the night but was unable to recall who it was to whom she had directed this question. She recalled that she was informed that Mrs Lioulios had *"come in and been quite loud and noisy during the night and that she'd finally fallen asleep before we had gotten there. Yeah, that's all I can remember them saying".*

142. Constable Lane recalls he provided a verbal briefing to the Custodial Officers who attended the Watch House, informing them that Mrs Lioulios had been subject to 15 minute observation checks because she had threatened suicide.

143. The information pertaining to the two CATT assessments of Mrs Lioulios that morning was not passed onto the Custodial Officers. The assessments were mentioned in the Statement of Facts, however, a copy of that was not contained in the BART file that was provided to the Custodial Officers.

144. Officer Murphy does not recall Officer Tracey stating anything about Mrs Lioulios being classified as a prisoner at risk.

145. Mrs Lioulios was woken so that she could be transferred to the Court cells. Officer Tracey was with Constable Lane when she woke Mrs Lioulios. Officer Tracey described Mrs Lioulios as a bit dazed and confused, however, she was able to follow directions.

146. Officer Murphy formed the opinion that Mrs Lioulios looked intoxicated when she was first brought out of the Watch House cell, describing her as appearing *"high"*, being unsteady on her feet and quite bleary and glassy eyed.

147. Officer Tracey conducted a pat search of Mrs Lioulios and handcuffed her to the front, placing her in the front of the Correctives' vehicle, separating her from the three male detainees. Mrs Lioulios was fully compliant the whole time.

148. On arrival at the Court cells, the male detainees were removed and escorted into the cells first. Officer Tracey and another female Custodial Officer escorted Mrs Lioulios around to cell 7, which is used for female detainees, it being separated from the other cells. Officer Tracey then removed Mrs Lioulios' handcuffs and informed her that she would have the opportunity to speak with the Legal Aid Solicitor before Court started at 9:30am. Mrs Lioulios still appeared confused and unsteady.

149. Mrs Lioulios advised Officer Tracey that she did not wish to see the Legal Aid Solicitor and that she did not need any legal advice. Prior to going to the court room, Mrs Lioulios sat quietly in the cell without incident.

APPEARANCE AT THE ACT MAGISTRATES COURT

150. About 9:45am the Court cells received a call for Mrs Lioulios to be brought up to Court Room 1. Officer Tracey escorted Mrs Lioulios, who had refused to see the duty Solicitor from Legal Aid or seek any legal assistance from the cells to the court room.

151. Mrs Lioulios was formally charged with the offence of contravention of the Protection Order and the Magistrate inquired as to whether she was

represented by a solicitor and was advised that she was not. The Prosecutor advised the Magistrate that bail was not opposed but conditions were sought which substantially copied those of the Protection Order. Mrs Lioulios asked where the conditions had come from and was advised that they had been suggested by the Office of the DPP. She then asked *"And can I ask on what basis?"* and was advised because of the breach of the Protection Order. The Magistrate asked Mrs Lioulios whether there was something she did not agree with and she replied:

> *"I'm just wondering whether …*
> *I'm sorry. I'm just wondering if Hugh wanted those conditions in place."*

152. A discussion took place between the Magistrate and the Prosecutor in which the Prosecutor advised that the conditions sought were not as requested by the Police but were merely taken from the Protection Order that was in place.

153. The Magistrate then addressed Mrs Lioulios as follows:

> *"They're the conditions that presumably are on your protection order, and they're the conditions that you have breached. So if you don't agree with those conditions then what you're really saying is that you're going to keep on breaching the conditions of the protection order."*

154. Mrs Lioulios then said:

> *"Well it was my understanding that Hugh was taking the order back."*

155. The Magistrate then counselled her as follows:

> *"Well if that hasn't happened then the order is still in place, and if those conditions mirror the protection order you can't do that anyway because you'll be breaching the protection order. So you'll be arrested again if you break any of those conditions."*

156. The normal practice is for the conditions sought by the Informant or the Prosecution to be put in writing on a pro forma and both the Prosecution and the Defence sign them and the form is handed to the Presiding Magistrate. In this instance, it appears the form was handed to Mrs Lioulios as she told the Magistrate who asked for the *"sheet"* that:

> *"There's no signature."*

157. The Magistrate replied:

> *"That doesn't matter, you'll have to sign a bail condition. If you don't sign your bail you'll be remanded in custody. So, that's a matter for you, that's your choice whether you sign your bail conditions or not, but this is the bail that I'm going to put you on ..."*

158. Shortly afterwards Mrs Lioulios asked why the Magistrate was calling her by her maiden name of Chacos and was advised that that was the name under which she had been charged.

159. The Court Officer who was the designated Bail Officer for the day indicated that Mrs Lioulios refused to sign her bail and said she refused to agree to the final condition concerning compliance with the Protection Order. He said that she had indicated to him that she had thought the order was to be withdrawn. He explained to her that if she did not sign her bail papers she would have to return to the Court cells until the matter could be returned to the Court. She declined to sign her bail papers saying words to the effect that *"I don't care, I'll stay in these cells for the rest of my life. I'm not signing that bail".*

160. The Bail Officer described Mrs Lioulios as:

> *"she looked like she was on another planet, just staring – staring through me, she didn't look at me, and just didn't seem with it, yeah. She, yeah, didn't look real good ... She wasn't being aggressive, very slow, slow in her movements when I called her up and she just kind of stared through me and when I read out the last condition, that's when she got a bit aggressive, that's when she was like* 'No, I'm not signing that, I refuse to sign that condition,' *and not overly aggressive but just – just aggressive in general."*

161. A short time later, Mrs Lioulios was taken back before the Magistrate who inquired as to whether she would sign the bail papers and she replied that *"he asked to revoke his order when I revoked my order yesterday ... and he didn't do that. And his order is based on lies and I consented to it."* The Magistrate advised her that if she did not sign her bail conditions she would be remanded in custody, to which she replied *"I want to rot in gaol"* and asked *"Why isn't he here answering to this? Why isn't he here answering to this?"* She said she was the one who had contacted the police and reported the breach of the order and continued:

> *"But he promised me he was revoking that because he said if I write to the Medical Board and revoke my statement against him, if I take my statement out … and he hasn't fulfilled his part of the bargain … he needs to be here telling me why he didn't – I mean, he blackmailed me ... to take my statement from the Medical Board. He blackmailed me to take away my DVO and I did what I was supposed to do …"*

162. The Magistrate asked Mrs Lioulios whether, if she was granted bail, she would contact Dr Veness and she replied *"Yes"* and again said that he had promised to revoke *"that".* She further said that she would visit him and the Magistrate told her that that was tantamount to saying that she was going to continue to breach the Protection Order to which she replied:

"I did what I was told to do. He told me to take away my statement to the Medical Board about his drug use and his violence and his wrong doings, I took that away. He told me to take away the protection order because he was violent towards me, and I took that away, now he's put this in place. He has to … he has to …"

163. The Magistrate inquired as to when she had her Protection Order in place and Mrs Lioulios replied:

"Yes, I've had an order against him since November. He has been blackmailing me all this time and I finally can't take it any more and I agreed to take it away yesterday. He agreed to take his away."

164. Mrs Lioulios told the Magistrate that she intended killing herself after she had done her gaol time and that she was on medication prescribed by Dr Melvin Bennett and Dr Ron Lee. The Magistrate had read the statement of facts prepared by the arresting police in which the defendant had made the same threat to self harm.

165. The Magistrate remanded Mrs Lioulios in custody for a period of two weeks, refused bail and remanded her in custody. She marked the file *"Prisoner At Risk"* and ordered that a psychiatric assessment be undertaken. Her matter concluded at 10:19am.

RETURN TO THE ACT MAGISTRATES COURT CELLS

166. About 10:20am Officer Tracey escorted Mrs Lioulios back to the Court cells and placed her back in cell 7. Mrs Lioulios did not say anything at this time and sat in the cell without incident.

167. Not long after Mrs Lioulios was brought back down to the Court cells, she was escorted to the induction counter and underwent the process required when a detainee is first remanded in custody, which process was conducted by Officer Fraser. She was asked several questions, the answers to which were hand written on a pro forma induction questionnaire, then later entered onto the computer system. Mrs Lioulios was relatively unresponsive, mainly answering questions by nodding her head, however, she gave some limited verbal answers.

168. During the induction, Mrs Lioulios informed Officer Fraser that she had attempted self harm the previous day, however, would not provide Officer Fraser with any further details. Mrs Lioulios also informed Officer Fraser that she was depressed but again did not elaborate and merely shook her head when asked if she was on any medication.

169. Officer Fraser gave Mrs Lioulios the opportunity to make a phone call. She attempted to ring her husband and sister, however, could not contact them. Both were at the Court trying to find out where she was. She then called Miss Batterham and had a brief conversation with her.

170. She asked Miss Batterham to call her sister and tell her to come to the Court House and also asked her to tell Dr Veness to remove his Protection Order. Mrs Lioulios told Miss Batterham that she had seen the Magistrate, but Miss Batterham said she was unsure as where Mrs Lioulios was calling from. Mrs Lioulios sounded upset on the phone, however, she was not crying at the time. The phone call lasted for about one minute and following it Miss Batterham contacted Mrs Lauro as requested.

171. After the induction was completed, Mrs Lioulios was escorted back to cell 7, where she sat down without incident.

172. At 12:30pm Melissa Carpenter was remanded in custody and was escorted down to the Court cells and placed in cell 7 with Mrs Lioulios. When Miss Carpenter was first brought down to the Court cells, she was upset. Mrs Lioulios was trying to console her and informed her of the circumstances surrounding her own arrest. Miss Carpenter said in evidence that she told Mrs Lioulios that she had been in custody before and that if she needed to know what the procedure was, or if she needed any help, that she was prepared to assist her, it being her first time in custody. Mrs Lioulios then asked her if she would assist her to commit suicide.

173. She said that she replied that it was a really selfish thing to do as she had just finished telling her about her two daughters. She said that she did not know whether she was serious or not, although she was *"a bit upset".* She did not tell any of the Custodial Officers of this request.

174. About 1:50pm Officers Thackeray and Tracey attended cell 7 for the purpose of conducting strip searches on both Miss Carpenter and Mrs Lioulios as part of the induction process for a person remanded in custody. At this time Miss Carpenter and Mrs Lioulios were talking with each other. Mrs Lioulios did not appear happy, however, she did not appear upset either.

175. Miss Carpenter participated in the strip search, which was conducted in the shower next to cell 7 as there were no closed circuit cameras in this area, and following that search she returned to cell 7. Officer Tracey was aware that this was the first time Mrs Lioulios had been remanded in custody and explained the process to her to offer her some reassurance. When being taken to the area where the search was to be conducted, Mrs

Lioulios said words to the effect that the Custodial Officers *"just wanted to bash her"* and that *"Custodial Officers have a lot of pent up, angry aggressiveness*. *She made "oohing" and "aahing noises like sexual groaning noises. She also called them 'aggressive Anglo Saxons'"*. During the search Officer Thackeray asked Mrs Lioulios some general questions including whether she understood that she had been remanded in custody. Mrs Lioulios responded that she did not understand why she had been remanded in custody and it was then explained to her why she had been so remanded and what that meant. Mrs Lioulios was compliant during the search and was not upset.

176. Following the search, Mrs Lioulios was being escorted back to her cell when she crouched on the floor and began crying. Officer Tracey tried to console her but she did not respond and continued to cry. Mrs Lioulios was asked by Custodial Officers to move back to her cell, however, she was unresponsive and the Custodial Officers took hold of her under the arms and asked her to stand up, but she remained unresponsive and non compliant. She was then carried to cell 7. The Custodial Officers stopped to rest on the way to the padded cell and at that point Mrs Lioulios *"made remarks like '*O yeah, get your baton out, give it to me, you know you want to*'"*. Once placed in cell 7, she put her hands over her ears, rocked backward and forward, screaming and crying and, according to Officer Tracey, *"was inconsolable".* The Custodial Officers shut the cell door and advised the duty supervisor, Officer Cannon. Officer Thackeray remained outside of the cell keeping Mrs Lioulios under observation.

177. A short time later Officer Tracey and Officer Cannon returned to the cell and saw that Mrs Lioulios was still very upset. They entered the cell and removed her shoes as they had laces in them.

178. Mrs Lioulios remained sitting on the floor with her hands around her legs. Melissa Carpenter said she kept asking to make a telephone call *"to the Grow or the Rainbow Community or something … .I think it might be like a counsellor or counselling thing"* and she was told that someone would come and see her *"in a minute"*.

179. GROW (ACT) as described on its homepage

> *"is a community mental health organisation which began in Sydney Australia in 1957 and is now international. It is a mutual self help group for people suffering from any mental illness including depression, anxiety, stress or life crisis and follows a 12 step program of personal growth toward mental health".*

180. Shortly thereafter she commenced to bang her head against the wall of the cell. Custodial Officers attended the cell again and Officer Tracey placed her hand in between the wall and Mrs Lioulios' head while Officer

Cannon tried to talk to her and console her. Mrs Lioulios did not respond and continued crying. After a while she calmed down slightly and stopped hitting the wall with her head. The Custodial Officers then left the cell, but before they left the area she resumed banging her head against the wall again.

181. Miss Carpenter then gave evidence that one of the Custodial Officers, one of the male officers, then suggested that they should call Mental Health to Mrs Lioulios but a female officer replied *"No, it should be OK, they can see Mental Health when they get to the Remand Centre".* The practice is for all remandees to be assessed by Mental Health workers at induction into the BRC. No evidence of this was given by any Custodial Officer.

182. Officer Cannon decided to move Mrs Lioulios to cell 1, which is a semi-padded cell used for persons who threaten to self harm or are self harming. The walls are padded, however, the front of the cell is a perspex window like the other cells. It is the only padded cell within the Court cells. At the time of the decision to move Mrs Lioulios into this cell it was unavailable as it had to be decontaminated due to another prisoner urinating in it earlier in the morning.

183. About 2:15pm after cell 1 had been cleaned, Officers Tracey, Thackeray, Cannon and Waters entered cell 7. Mrs Lioulios struck out attempting to kick at Officer Tracey and Officer Thackeray, making no contact with either of them. She was then handcuffed to the front of her body and was unresponsive to directions to move. She was carried by the four Custodial Officers to the induction area within the cells. She was placed on the ground briefly to rest as she was completely non compliant, but not physically aggressive. During this time she made several verbal outbursts referring to Custodial Officers as *"Homosapien Anglo-Saxons"* and requesting that they hurt her with their batons. Mrs Lioulios was also saying to the Custodial Officers that they just wanted to bash her. The Custodial Officers explained to her that they did not want to hurt her, that they were trying to help her. She was then carried the rest of the way and placed in cell 1.

184. After moving Mrs Lioulios to cell 1, the Custodial Officers returned to the control room which has a direct line of sight to cell 1. The Officers had, and continued to maintain, constant observation of Mrs Lioulios. Shortly after being placed in cell 1, she began banging her head on the glass frontage of the cell. At about 2:20pm, Custodial Officers observed that Mrs Lioulios had removed her bra and appeared to be trying to get the underwire out of it. Officers Tracey and Cannon entered the cell and Officer Tracey took the bra from her while Officer Cannon distracted her.

185. After they left the cell Mrs Lioulios removed her track-suit pants and underwear and wrapped her underpants around her neck, making attempts to hang herself, however, there were no anchorage points within the cell. Mrs Lioulios then put the sleeve of her jumper into her mouth in an apparent attempt to choke herself.

186. Officers Cannon, Tracey, Thackeray and Murphy entered the cell and removed the jumper, track-suit pants and underwear from Mrs Lioulios. The handcuffs were removed during this and she was then put in a tear-proof smock, sometimes referred to as a *"suicide smock".* This smock is used generally for detainees who are attempting to self harm in order to prevent them using their clothes to do so and at the same time to allow them to maintain their dignity. The handcuffs were reaffixed on Mrs Lioulios after the smock was placed on her. Mrs Lioulios then lay down on the bed. Miss Carpenter told the hearing that such a smock is generally known as either a suicide smock or a suicide vest.

187. The Custodial Officers had been required under their standing orders to prepare incident reports concerning the use of force on the detainee. They did so and these reports were tendered at the hearing.

188. A short time later Officer Cannon, the senior officer on duty in the Court cells that day, requested two Custodial Officers to escort the two female prisoners to the BRC. Custodial Officers Ian Dew and Keegan Watts volunteered to do the escort as they had not been involved in any of the use of force incidents with Mrs Lioulios, therefore they did not have to complete incident reports, which is what the other officers were occupied in doing.

189. The entries for the vehicle used for the transport of the remandees shows that the journey to the BRC commenced at 1445. Mrs Lioulios had been in the Court cells since approximately 8:00am that day and had been remanded in custody at 10:20am. I was informed that, generally, warrants for the detention of a person following his or her remand in custody take about an hour to be prepared by Court Staff and taken to the Court cells to allow for the removal of the detainee to the BRC. Mrs Lioulios, whom the Custodial Officers knew was marked as a *"Prisoner At Risk"* by both the Watch House Sergeant and the Court, was kept in custody in the Court cells for four and a half hours after she was remanded in custody. This is not an acceptable practice. Priority should be given by Court Staff to the preparation of detention warrants of persons marked *"At Risk"* and these must be taken immediately following their preparation and signature to the Court cells to allow for the immediate removal of such a detainee for assessment and treatment by Mental Health workers.

190. The Departmental van used to transport Mrs Lioulios and Miss Carpenter was a Toyota Hi Ace van which had two internal cells, capable of holding five detainees. The compartments were one behind the other running down the vehicle. There was no closed circuit television to allow the transporting Custodial Officers to keep the prisoners under surveillance. There was no capacity for such officers to observe any prisoner placed in the rear compartment of the van during transit. Any prisoner in the first "cell" could be observed with difficulty.

191. Miss Carpenter was placed in the front compartment of the transport van prior to Mrs Lioulios being removed from her cell. Mrs Lioulios had declined to rise from the bed on which she was lying and walk to the transport van and was non-co-operative. She was then carried by two Custodial Officers to the van with her feet dragging along the ground.

192. When they got around to the van doors she was placed down whilst one Custodial Officer got into the van, then took her by the arms while the other took her legs. They then lifted her into the rear compartment. They attempted to place her on the bench seat within the compartment, but she was still non co-operative and moved down from the seat to sit on the floor, where she was left. Officer Munro had to step back over Mrs Lioulios to get out of the compartment. Mrs Lioulios remained handcuffed to the front of her body and dressed in the tear-proof smock. The seat belts which were fitted to the compartment bench seat were not fastened around her.

193. The escort vehicle Custodial Officer passenger was unaware at the time that Mrs Lioulios had been classified a "*Prisoner At Risk"*. When he saw that she was in a tear-proof smock he thought that she may have been at risk, however, he did not recall being told or seeing anything the alert "*PAR"* on the file. The driver said that he had become aware of her status shortly prior to his removal of her from the Court and he had observed some of her behaviour within the Court cells.

194. The Court Transport Unit Standing Order 20 *"Prisoners at Risk"* describes a prisoner at risk as *"a prisoner at risk of harming or killing themselves".*

195. The procedure to be followed when a prisoner is classified at risk is to maintain 15 minute observations, at a minimum, of the prisoner. These observations were recorded on Mrs Lioulios' prisoner observation sheet.

196. The Standing Order also states that an officer is to contact the Manager of the CTU when they become aware of a prisoner's threat to self harm. Officer Cannon regularly updated Acting Superintendant Johnston at the BRC of the incidents involving Mrs Lioulios.

197. Section 20.6.2 of the Standing Order states that if there is a threat of self harm that is related to an impending escort (such as transfer to a NSW Correctional Facility) that Manager of CTU shall direct that the prisoner not participate in the escort until the completion of an assessment by Mental Health professionals and the Manager of the CTU is satisfied that it is safe to do so.

198. The ACT Corrective Services Prisoner Escort, Police and Prisoner Escort Procedures make no reference to the issue of *"prisoners at risk".* It is a commonly held view amongst the Custodial Officers that all the prisoners that are *"fresh in custody"* at the Court cells are classified as *Prisoners At Risk* until they are assessed at the BRC. As part of the induction process on arrival at the BRC prisoners are assessed both medically and mentally.

199. The Team Leader, Forensic Services for Mental Health ACT, advised the inquest hearing that a Court Liaison Officer was, at July 2008, and still is, responsible for providing a link between Mental Health ACT and the ACT Law Courts. The duties of that Officer, among others, are:

    1. to provide information to the judicial officers of the Courts concerning any defendants who are or have been in receipt of services from Mental Health ACT.
    2. to provide advice to judicial officers concerning risk factors and treatment options for defendants both in custody or in the community.
    3. to assess defendants before the Courts who display symptoms of mental illness and who may require immediate care and treatment at a hospital under the provisions of the Crimes Act 1900. In this category, the Officer responds to concerns from the Court, legal representatives or Corrective Services or the Australian Federal Police.

200. The Team Leader informed the inquest hearing that the Liaison Officer was, and remains, available to staff of the Court cells. The services of the Liaison Officer were not called upon at any time on 4 July 2008 to assist or assess Mrs Lioulios.

TRANSFER TO THE BELCONNEN REMAND CENTRE

201. About 2:45pm the transport vehicle left the Court cells to drive to the BRC. The vehicle used to convey Mrs Lioulios was a white Toyota Hi-Ace van bearing ACT Government registration 212 833. It was also given the name Romeo 3 (R3). The van has two compartments fitted in the rear of the vehicle. The compartments are accessed from a sliding door on the passenger side of the vehicle, each compartment is secured by two sliding locks fitted with padlocks. There is a clear perspex panel, about 100cm

long by 50cm wide, separating the front seat of the vehicle and the first compartment. There is metallic wall between the two compartments with a clear perspex area within this panel, about 57.5cm long by 13cm wide. Visibility into the compartments is not assisted by video camera.

202. Custodial Officers indicate that a person in the front compartment can be seen from the front seat of the vehicle only when they are very close to the perspex screen. When a person is at the rear of the front compartment they are difficult to see. Visibility from the front seats of the vehicle into the rear compartment is non-existent. Lighting within these compartments is installed and can be operated from the front seat of the vehicle. This lighting was not turned on but does not assist with visibility to the rear compartment.

203. The CTU has another similar Toyota Hiace van and a larger Mercedes Sprinter. Both the Hiace vans have two compartments and no cameras to monitor the compartments. The Mercedes Sprinter has three separate compartments and also has cameras that monitor the compartments.

204. The Mercedes Sprinter vehicle log shows that it was taken from the Court cells at 2:00pm arriving at the BRC at 2:35pm.

205. Miss Carpenter said that she had looked through the window between the adjoining cells in the van but could not see Mrs Lioulios. She tapped on the window but did not get a response and so thought Mrs Lioulios was really upset and did not wish to talk. She said in evidence before me that *"I could just hear a couple of like thud noises"*. Miss Carpenter did not look into the other compartment nor did she say anything to the Custodial Officers. This information was told to Police at a later time.

ARRIVAL AT THE BELCONNEN REMAND CENTRE

206. The van arrived at the BRC at approximately 3:00pm and was driven into the sally port area. The passenger Custodial Officer conducted a perimeter search of the area. This search does not involve looking into the vehicle compartments but is a search of the area around the vehicle. It is also to ensure that no person has followed the van into the sally port before the roller door at its entrance is fully closed. One Custodial Officer carried the detainee's property and the other took the files concerning each prisoner into the induction area.

207. Miss Carpenter was removed from the van first and taken into a holding cell within the BRC. Due to Mrs Lioulios' previously unresponsive behaviour, further staff were requested to assist with the removal of Mrs Lioulios from the van and further Custodial Officers were in attendance to assist.

208. Approximately two minutes after the arrival at the BRC, the padlocks on the compartment holding Mrs Lioulios were removed and the door to the cell opened. Mrs Lioulios was observed to have her head close to the compartment door and she was given several directions to step out of the vehicle. Her head and top third of her body were resting on the bench seat and her legs were on the floor of the vehicle. A Custodial Officer following the directions touched Mrs Lioulios and got no response. He reached into the vehicle and saw a seat belt wrapped around her neck. The seat belt was secured into the clasp on the bench seat.

209. An ambulance and the BRC nurse were requested. The seat belt was undone and Mrs Lioulios removed from the van. No pulse was found and Mrs Lioulios did not appear to be breathing. CPR was commenced and an oxymask used.

AMBULANCE ATTENDANCE AT THE BELCONNEN REMAND CENTRE

210. A short time later ACTAS members arrived at the BRC. It was noted that Mrs Lioulios was not breathing and had no pulse. ACTAS members took over CPR (compressions and use of oxymask) and attempts were made to insert a cannula in Mrs Lioulios' left arm (near the wrist) and in the jugular vein on Mrs Lioulios' neck, which were both unsuccessful. ACTAS members intubated Mrs Lioulios and she was then recorded as having spontaneous cardiac output. ACTAS members did not administer any drugs to Mrs Lioulios during any part of their treatment.

211. Mrs Lioulios was placed in an ambulance and conveyed to Calvary Hospital. An Officer of Correctives travelled in the ambulance with Mrs Lioulios and the ambulance officers.

MEDICAL TREATMENT OF TANIA LIOULIOS

212. At about 3:45pm Mrs Lioulios was admitted to Calvary Hospital Emergency Department and about 5:20pm she was transferred to the Intensive Care Unit. Her state was unresponsive and a CT scan showed a hypoxic brain injury. Treatment was administered to cool Mrs Lioulios' body to between 32° and 33°. She was put into a deep induced coma for about 24 hours, after which her body temperature was increased.

213. Upon coming out of the comatose state, she showed indications of severe brain injury, including myoclonic jerks (generalised twitching of the body) and fixed, dilated pupils. During this time supported intensive care was administered to her, which involved breathing apparatus and medication to

assist her circulation. Anti-convulsive medication was also administered to address the myoclonic jerks, however, it was not effective.

214. About 72 hours after admission (7 July 2008) a further CT scan was conducted, which confirmed a massive brain injury. At this time it was expected by the Intensive Care Unit doctors that Mrs Lioulios would progress to brain death quickly. Supported intensive care continued so Mrs Lioulios could be assessed for organ donation.

DEATH OF TANIA LIOULIOS

215. Mrs Lioulios condition deteriorated and on 11 July 2008, as the prognosis was assessed as hopeless, care was not escalated. Calvary Hospital doctors were to withdraw supported intensive care from Mrs Lioulios at 3:00pm, Saturday 12 July 2008, however, she went astystole (loss of heart function) about 1425hrs the same day.

POST MORTEM EXAMINATION

216. On 15 July 2008 a Post Mortem Examination of Mrs Lioulios was carried out by Dr Lavinia Hallam at the Kingston Forensic Medical Centre. After the post mortem examination, Dr Hallam announced her interim findings were that the death was caused by hypoxic ischemic encephalopathy and was consistent with a hanging.

217. Dr Hallam provided a final report dated 11 February 2009 in which she reported the cause of death as hypoxic ischaemic encephalopathy with a morbid condition being a near miss hanging giving rise to the above cause.

COMMENTS

218. During this hearing I took what has been described as *"an unusual step"* of inviting the Director of Public Prosecutions for the ACT to act as a facilitator between agencies in an endeavour to implement agreed procedures and protocols between relevant agencies for the safety of persons in custody deemed *"at risk".* Mr White undertook this task willingly and co-operatively. I formed the opinion, after reading the brief of evidence relating to the final days of a well respected, professional woman in circumstances that can only be described as tragic, that Mrs Lioulios had been the victim of deficiencies from various agencies which were supposed to have been in place to support, protect and heal her in her desperate need. I will address those perceived deficiencies later.

219. I thank the Director for undertaking this task and I thank the agencies involved for their co-operation in arriving at a mutually beneficial set of protocols for the safety and protection of some of the most vulnerable and needy of our society. Too often those unfortunately afflicted with the incapacity to choose to act appropriately within the requirements of society offend against the criminal law. The criminal law is somehow seen as a conduit to provide, through Court orders, the assistance to find a remedy for such an incapacity or, alternatively, to provide a means of removal of such a *"socially unacceptable"* person from society. It falls outside my statutory powers to comment on the desirability or efficacy of this approach.

220. Counsel for the AFP in his written submissions observed that the power under subsection 52(4) of the Act to *"comment on any matter connected with the death, fire or disaster including public health or safety … "* is *"constrained by the touchstone of causation".* He cited *Re Doogan; Ex Parte Lucas-Smith and Others (2005) 193 FLR 239*. There the Full Court of the Supreme Court of the ACT said that *"Comments"* went *"beyond the scope of* 'findings*'"* and *"may extend to recommendations intended to reduce the risk of similar fires, deaths or disasters occurring in the future".*

221. In this matter I am of the view that the deficiencies in the protocols, practices and procedures for dealing with persons held in custody contributed to the unfortunate death of Mrs Lioulios. As such, I am of the view that not only am I statutorily empowered to comment, but to fail to do so on these deficiencies and to fail to suggest the implementation of remedial practices and procedures would render me derelict in performing my office.

222. I formed the view that in the interests of the protection of Prisoners At Risk these amended procedures, practices and protocols should be implemented as soon as practicably possible and that is why the Director was asked to facilitate this task whilst the hearing was on foot, rather than following the handing down of my findings and comments.

223. I have received a document entitled *"Recommendations of Round Table Group"* and I attach a copy of it. It traverses some of the areas in which I have commented. In parts it goes beyond the ambit of my legislative power in this inquiry. The recommendations numbered 6a and 7 are examples of this. I have attached it so that the co-operative approach of the agencies concerned can be recognized and their recommendations implemented by those agencies as matters connected with the public safety of persons in custody. Insofar as they relate to the administration of the Court, it is beyond my power as Coroner to recommend them. I thank

the parties to it and commend them for their co-operative approach to this exercise.

224. One criticism levelled at the AFP was the fact that Mrs Lioulios had been charged under her maiden name of *Chacos* and not her married surname. An explanation was given. This was far from satisfactory and seemed to be that, if a person had previously been entered into the AFP computer system under a then relevant name, that name remained as the principal or dominant name in all future matters concerning that person.

225. The use of the surname *Chacos,* in charging Mrs Lioulios, obviously caused her concern and distress, as is evidenced by her conversation with the Magistrate following her refusal to enter into the bail conditions imposed. Counsel for the ACT submitted that this failure should be perceived as partially instrumental in Mrs Lioulios not coming to the attention of the Forensic Court Liaison Officer at the Court on 4 July 2008. I do not accept that.

226. This failure had as its genesis the failure of the staff of Mental Health ACT from TCH noting for, or bringing to, the attention of the Court Liaison Officer the fact that there was a person in custody who had presented to it three times in the preceding eighteen hours. This failure is rendered totally unacceptable, particularly given the facts surrounding the presentation on two occasions whilst in custody. Mental Health ACT must be required, as part of its record keeping relating to assessments of persons in custody, to inform the Court Liaison Officer, or a designated officer, within the Forensic Services division of Mental Health ACT, of the facts and circumstances surrounding such assessments. This must be made possible by ensuring that a compulsory field on the computerised record keeping of the assessment is activated and complied with before the record is able to be closed. Any mandatory requirement to notify the Court Liaison Officer that a person who has sought, or is receiving, the assistance of Mental Health ACT workers should extend to persons attending Court whilst on bail as well as to those in custody.

227. The role of the Court Liaison Officer has not, from evidence given before me, been properly understood and certainly not appropriately utilised. Some Custodial Officers admitted that they were unaware that such an officer was available, when required, to attend the Court cells to assess a person in custody. This situation must be redressed. In saying this, I am aware that a person is regarded as a Prisoner At Risk whilst being held in the Court cells, until such time as he or she completes the induction process at the BRC, part of which is a psychiatric assessment.

228. The role of the Court Liaison Officer should be brought to the attention of members of the AFP, members of the legal profession, including members

of the Commonwealth and ACT DPP, members of Correctives and Court Officers. By doing so, defendants in custody will have available to them the services of this Officer. This will have the benefit not only of ensuring that defendants immediately receive such assistance as is required, but will also ensure, through appropriate communication with the prosecuting authority, that the Court is fully apprised of all matters relating to the defendant when considering applications for bail and conditions to be attached to any grant of bail.

229. I have commented on the assessment of Mrs Lioulios by Mental Health ACT when she was in custody. These documents relate to what I have described as a flaw in the difficult subjective assessment of the *"suicide risk"* of the patient on presentation. The decisions made concerning the initial release into the care of her husband and subsequently into the custody of the AFP were personal, subjective assessments. Any flaw in them was not, in my view, systemic.

230. In dealing with Mrs Lioulios the AFP Officers have not fully complied with the requirements of the Watch House Operations Manual and the Memorandum of Understanding with Correctives.

1. The BART file did not contain a photograph of the detainee by Watch House staff. No explanation was given for this failure.
2. Whilst the file was clearly stamped *"Prisoner at Risk"* there does not appear to have been any appropriate delineation of the risk category of the detainee. Why was she at risk? Such information must be provided for the protection of the detainee whether, for example, from self harm or from other detainees.
3. There was no full disclosure of the events of the preceding eighteen hours vis à vis Mrs Lioulios' obviously fragile, suicidal mental state. The clinical notes of Mrs Bickmore, relied upon by Sergeant Shakeshaft to justify the detention of Mrs Lioulios, were not included in the BART file. Acting Sergeant Horrocks in his evidence stated that it was his belief that she was not suicidal and thus he did not include the notes in the file. This explanation cannot be accepted in light of the totality of the evidence. Some short hours earlier, Mrs Lioulios' psychiatric condition was such that a Watch House Sergeant refused on two occasions to accept her into custody. The decision not to include the notes into the BART file was clearly inappropriate in the circumstances. All material in the possession of the AFP must be included in that file.
4. The concerns held by Sergeant Shakeshaft for the safety in custody of Mrs Lioulios were not appropriately documented and made available in that form to Custodial Officers who were tasked with her subsequent safe custody.

5. The full history of prior suicide attempts was not included in the file. Counsel for the Commissioner has realistically accepted that this information should have been so disclosed.

6. There was no proper briefing of the CTU of the known history of the detainee. The suggestion that Watch House staff had told CTU staff that Mrs Lioulios had been *"quite noisy, rowdy, throughout the night and had finally fallen asleep"* is difficult to comprehend. There is simply no evidence that she was anything but quiet and drowsy whilst in the company of AFP officers.

231. Counsel for the AFP has submitted, in effect, that the failure to include certain matters in the BART file was not of such significance as to lead to a causal link between them and the cause of death in this matter. That file had clearly marked on it that the prisoner was a Prisoner At Risk and, in the words of Counsel, *"must therefore have been obvious to even the most casual of readers*". That should have been initially sufficient, it was submitted, to alert Correctives of the special needs of the prisoner.

232. I agree that the deficiencies in information sharing between the agencies were regrettable and sustained efforts must be made to eliminate them through protocols and mutually agreed practices and procedures. Ongoing training and supervision must become a part of this process to eliminate complacency and inappropriate deviation from these practices and procedures and to provide an opportunity to review and update them. I recommend that the agencies which have met with the Director of Public Prosecutions meet regularly in a spirit of mutual co-operation to review and revise the agreed protocols and procedures.

233. The Custodial Officers should have been advised of the prisoner's sustained threats of suicide to members of the AFP during her time in custody with that agency.

234. I am satisfied that the conduct of the AFP and the failings of it as outlined above in my findings were not causative of Mrs Lioulios' death. They were failings and shortcomings in the system in place for the safe custody of prisoners at risk and must be redressed.

235. Counsel for the ACT submitted that *"the events of 3rd and 4th July 2008 point to a breakdown in communication".* The submission on behalf of Correctives seems to have been based on the proposition that it lacked full information concerning the prisoner's conduct and observations and assessments of her mental condition over the preceding 24 hours and that, had Correctives had available to it all known facts, its care of the prisoner would have been different.

236. I am of the view that Correctives, through its Officers in the CTU, had available to it sufficient information, both on file and certainly through observation, to have been alerted to the prisoner's mental condition. The conduct of those Officers can, in my view, only be described as deviant from that standard of care expected for the protection and safekeeping of a person exhibiting significant mental difficulties.

237. I say this for the following reasons:

1. The file was clearly marked *"Prisoner at Risk"*. Whilst the practice of Correctives was to treat each prisoner in its care as such until delivered to the BRC, this was a case where another agency had categorised the prisoner as requiring special needs.
2. Officers from Correctives had been present at the Bail Office, when the prisoner had refused to sign her bail, and in Court when she informed the Magistrate that she intended taking her own life when released from custody – i.e. they must have been aware that she had displayed suicidal ideation.
3. The prisoner had at induction indicated that she had attempted self harm the previous day and that she was depressed.
4. The prisoner was removed from the cell she shared with another female for her own protection, and the protection of that other prisoner, as a result of her behaviour.
5. The prisoner's conduct and goading utterances in transit to and from the area where she undertook a strip search can only be described as provocative and presumably uncharacteristic.
6. Following the strip search of the prisoner she became initially non compliant in her attitude and then, in my view, undertook behaviour that can only be described as attempting self harm. This involved removal of her clothing, including her undergarments, and using them, if not to actually attempt self harm through strangulation or hanging with them, certainly to indicate that was her intent. It further involved the stuffing of her jumper into her mouth in what might be seen as an attempt, or at very least an indication, that she was to choke herself with it. Custodial Officers, having previously removed her shoes as they had laces in them, took her clothing from her and placed her in what is colloquially known as a *"suicide smock".* At the time she was in the words of one of the Custodial Officers *"unconsolable".*

   The recording from the security cameras in the Court cells was in evidence before me and it shows quite disturbing footage of the prisoner banging her head violently against the perspex window of the cell. Counsel assisting me submitted that the times she did so numbered significantly in excess of 200.

   Counsel for the ACT submitted to me that the above behaviour was to be described as non compliant behaviour as it had been so categorised by some of the Custodial Officers. I accept that each

piece of individual conduct might be so described but I am unable to accept that any responsible officer apprised of the totality of the prisoner's conduct could so describe it. I accept that from time to time prisoners exhibit various aspects of that conductm, but not in total. Knowing that a prisoner had been marked as a *"Prisoner At Risk"* by another agency and who had threatened to take her life and self harm and who refused to sign her bail papers and then exhibited the conduct in the Court cells as described to me could not, in my view, have been reasonably seen by an experienced Custodial Officer as being anything other than psychiatrically ill.

7. No attempt was made to engage the services of Mental Health ACT, either through the services of the Court Liaison Officer or through an expedited removal to the BRC, where on induction the prisoner's mental health issues would have hopefully been recognised and treated.
8. There was no appropriate compliance with Standing Order 20 of the Court Transport Unit Standing Orders. That provides that where an officer notes that a prisoner has attempted suicide or self harm that officer *"shall immediately report"* it to the Manager of the Unit who *"shall immediately reclassify the prisoner (if not already identified as a PAR) as a prisoner at high risk and notify the Superintendent BRC".* In the evidence before me there was evidence that the prisoner was thought to be attempting suicide. There is, as I have found, evidence to show that at the very least the prisoner was attempting to self harm. There does not appear to have been any report to the Manager and there was no reclassification of the prisoner with the then encumbent requirement to keep her under 5 minute observations. This requirement must have extended to the transport of the prisoner to the BRC.

   This Standing Order needs revision. I am unable to understand why the exception to the reclassification is included. Surely if a prisoner is classified as a prisoner at risk and is subject to 15 minute observations and then attempts to suicide or self harm, they should be subject to 5 minute observations. I have looked for a reason in the Standing Orders but have been unable to find any.
9. The prisoner was transported to the BRC in an unsuitable vehicle, without appropriate provision for her safety and without any inquiry being made as to the availability of a suitable vehicle. The explanation given for the decision to transport Mrs Lioulios to the BRC in the back cell of the vehicle is unacceptable.

238. There is evidence before me of the changes to the systems in place as a result of inquiry into the policies and procedures in operation for the safe keeping of Mrs Lioulios and her transport to the BRC. That inquiry was conducted by the Probity and Performance Division of the NSW

Department of Corrective Services. A report was provided to Correctives. I have indicated that I received a copy of that report but have not read it or caused it to become part of the evidence in this hearing.

239. My reason for so doing was that it did not fit within the statutory criteria for matters to be considered by me. The result of this report is a change of policies and procedures in the CTU. These changes are welcome and, in my view, recognise many of the deficiencies in either the system and procedures in place as at July 2008 or their implementation.

240. A *"Prisoner Alert Sheet"* is now completed at handover of each prisoner in the Police cells. It is a record of the questions asked of, and the answers given by, the AFP Officer to the Correctives Officer on handover. The questions are exhaustive and cover issues of attempted self harm, behavioural and medical issues and other issues thought relevant to the prisoner's welfare and safekeeping. I recommend that this form be signed by both the AFP Officer and the Correctives Officer involved in the handover of the prisoner. This can then reduce any subsequent conflict as to what was said and occurred on that occasion. I am advised that the handover procedure is now recorded in the Police cells. This Prisoner Alert Sheet is a necessary safeguard to the breakdown of that recording or conversations that are not coherent or audible.

241. The level of the Officer in charge of the CTU has been upgraded and it is his or her responsibility to assess all information available on reception of a prisoner and to make a risk assessment of each prisoner, using a pro forma developed, presumably, to provide consistency in and adequacy of that assessment. Specific criteria are set out to assist in the assessment of a Prisoner At Risk categorisation. That risk assessment is also used for deciding the mode of transport of a prisoner from the cells to the BRC.

242. The mode of transport has also been revised. No longer is a vehicle such as that used to transport Mrs Lioulios to be used. All vehicles have lighting, cameras and intercom systems to allow for communication between Custodial Officers and prisoners and to enable 5 minute observations to take place. Seat belts in the vehicles have been rendered less likely to be able to be used to suicide. Special provision is made for prisoners at high risk of harm. They are to be transported in a station wagon with Custodial Officers seated on either side of them.

243. A Monitor Officer is now stationed in the Court cells to continually monitor each remanded prisoner at 15 minute intervals, more frequently as provided for prisoners at high risk of harm and juveniles in custody.

244. Mrs Lioulios was taken into the custody of Correctives sometime shortly after 7:30am and was not removed from the cells following her court appearance that had been completed at 10:20am for transport to the BRC

until 2:45pm. In my view, this delay in removal to Belconnen is, unless there are exceptional circumstances, unacceptable.

245. I recommend that persons whose files are specifically marked *"Prisoner At Risk"* be afforded access to the Court Liaison Officer from Forensic Services for Mental Health ACT. This should take place as soon as is practicable after the prisoner is transported from the Police cells to the Court cells. Priority should be also given to access to legal advice to the prisoner. The Prosecution should then be advised of the custody of the prisoner so that he or she can advise the Court and arrangements made to have priority given to that matter. This practice will, of necessity, depend on the co-operation of both Mental Health ACT and the Legal Aid Office.

246. This should be so whether the application is for bail, which may or may not be contested, or whether an application is made for the assessment or treatment of the prisoner's mental condition. Priority should then be given to the preparation to the warrant for the removal of the prisoner from the Court cells in accordance with the order of the Magistrate. Priority should be then given to the removal of the prisoner from the Court cells to the BRC or to another facility for the assessment and/or treatment of the prisoner.

247. In keeping with the spirit and intent of the Coroners Act 1997, I forwarded to the parties to whom leave was granted to appear at this hearing a copy of my comments and proposed recommendations as set out in these findings. I received replies from Counsel and attach them to these findings and nothing in them has caused me to resile from my original recommendations and comments.

FINDINGS

248. Pursuant to section 52 of the Act I make the following findings:

1. The deceased was TANIA PAULINE LIOULIOS whose maiden name was CHACOS.

2. The deceased died at Calvary Hospital on Saturday 12 July 2008.

3. The deceased died from hypoxic ischaemic encephalopathy with the antecedent cause being a self caused near miss hanging in the rear of an ACT Corrective Services' vehicle whilst being transported in custody to the Belconnen Remand centre on Friday 4 July 2008.

249. In conclusion I commend the investigators assigned to assist me in this investigation led by Senior Constable Sally Nayda. The brief of evidence supplied was thorough and professional in its investigation and preparation and the diligence of the Officers in meeting deadlines and expectations has meant that this hearing has been able to be conducted in a timely manner. The trauma and grief of the immediate family of the deceased has been lessened and they have been able to seek closure in relation to this unfortunate death of their wife, mother and sister.

G C Lalor
Coroner

AUSTRALIAN CAPITAL TERRITORY

1st Floor
Reserve Bank Building
20 - 22 London Circuit
Canberra City ACT 2601

DPP

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OFFICE OF THE
DIRECTOR OF PUBLIC PROSECUTIONS

Our Reference:
Your Reference:

6 March 2009

The ACT Chief Police Officer
Australian Federal Police
Attention: A/Supt Rod Anderson

Executive Director
ACT Corrective Services
Attention: Anthony Johnston

The Chief Executive
ACT Health
Attention: Len Lambeth

Ms Helen Child
ACT Courts Administration

Dear All,

ROUND TABLE GROUP

I have forwarded the recommendations of the round table group to the coroner. I enclose for your records a copy of the letter and recommendations.

The matters which must now be attended to are the redesign of the CUSTODY TRANSFER FILE COVER SHEET (a draft of which Rod Anderson has now circulated), and the drafting of the service level agreement to embody such of the recommendations as are relevant to the member of the round table. I am more than happy to continue to assist, however, the detailed drafting is a matter for your organisations.

Yours faithfully

Jon White
Director of Public Prosecutions

Encl

AUSTRALIAN CAPITAL TERRITORY

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OFFICE OF THE
DIRECTOR OF PUBLIC PROSECUTIONS

Our Reference:
Your Reference:

6 March 2009

Coroner Lalor
ACT Courts
Knowles Place
CANBERRA CITY ACT 2601

Dear Coroner Lalor,

ROUND TABLE GROUP

As you are aware, in conjunction with the inquest that you are currently conducting into the death of Ms Lioulios, at your request I convened and facilitated a forum of relevant agencies to consider issues of procedure that had been raised as a result of your inquiry.

The forum, know as the round table group, consisted of the following agencies:

Australian Federal Police ("AFP");
ACT Corrective Services ("ACTCS");
Mental Health ACT ("MH"); and
ACT Courts Administration.

The round table group now makes a series of recommendations to you. These are enclosed.

In relation to Recommendation 7, for completeness I also enclose a copy of the request sent by the round table group to the magistrates.

Please note that work on redesigned forms and a detailed service level agreement to embody such of the recommendations as relate to the members of the round table group will now be the responsibility of the members of the group themselves.

To this end the AFP have circulated a draft of the redesigned CUSTODY TRANSFER FILE COVER SHEET for comments by the other members of the round table.

Yours faithfully

Jon White
Director of Public Prosecutions

Encl.

RECOMMENDATIONS OF ROUND TABLE GROUP

The round table group brings together the following agencies and bodies:

Australian Federal Police ("AFP");
ACT Corrective Services ("ACTCS");
Mental Health ACT ("MH"); and
ACT Courts Administration.

The round table is facilitated by the Director of Public Prosecutions ("DPP").

The round table group makes the following recommendations. It is not appropriate for the ACT Courts Administration to join in Recommendations 6 and 7 as these relate in part to the operation of the courts, and they do not do so.

Recommendation 1: The need for common terminology

The term "person at risk" should be adopted to cover all the categories of risk. The various categories of risk should be defined. One such category should be "self harm". Persons at risk of suicide would fall within this category. The category would encompass minor self inflicted injury through to suicide risk.

The documentation handed from the AFP to CS will be amended in line with this recommendation. Relevantly to the current issue, the term "self harm" will be stamped prominently on the cover of the file.

Recommendation 2: When the information on self harm is to be communicated

It is important that the information on self harm be communicated at every appropriate time. This will include:

- Between arresting police at time of arrest
- On initial lodgement at the watch house
- On shift changes at the watch house
- On handover by AFP to ACTCS at the watch house
- On lodgement in the court cells
- To any person who takes over custodial responsibility
- To the magistrate before whom the person appears
- To the prosecutor
- To persons having responsibility for transport of the person
- On reception into custody on remand or otherwise

Recommendation 3: The risk of self harm is to be communicated both verbally and in writing as appropriate

The document emanating from the AFP, currently headed "SPECIAL CONCERNS OR RISK FACTORS" will be redesigned to ensure that it is as readable and concise

as possible. If self harm is a risk factor, that factor should be clearly stamped on the file cover.

There is also an acknowledged need for oral communication to supplement and update the written record.

The written record should be updated with relevant information by the agency having custody from time to time of the person at risk. The updated file should accompany the person at risk and be handed to whoever assumes custody of the person from time to time.

Recommendation 4: The role of Mental Health ACT

The potential role of MH begins when a person is lodged in the court cells by ACTCS. MH will assess any person who has been lodged in the court cells who has been categorised a person at risk for mental health reasons. This will include (but not be limited to) all persons categorised at risk on the basis of self harm.

MH will also check all names of persons in custody in the court cells against the MH database to see if any such persons are existing clients of MH, or persons of whom MH is otherwise aware.

MH are otherwise available to see a person in custody at any time if requested by ACTCS.

MH will if required conduct a fitness to travel assessment if a person at risk is remanded in custody by the court.

Recommendation 5: How the protocols are to be embodied

The protocols embodying the understanding and recommendations herein will be embodied in one document to which each of the relevant bodies, that is to say AFP, ACTCS, MH, and the ACT Courts Administration will be a party. The document will be a service level agreement between those bodies. The parties will begin work on that document immediately.

Recommendation 6*: Time in custody in the court cells should be minimised

This has a number of aspects. However the central principle is that a person in custody is entitled to be dealt with as soon as possible. A corollary is that longer a person spends in the court cells the greater the risk to those responsible for the person's custody.

In the chain of custody, the court cells are the weakest link so far as dealing with persons with mental health issues is concerned.

Consonant with the central principle, the following specific recommendations are made.

Recommendation 6a: There should be a separate bail list starting at 9.30am each week day. This will enable questions of bail to get prompt and focussed attention.

Recommendation 6b: Priority should be given to by court staff to the preparation of warrants and other documentation relating to person at risk of self harm, so as to minimise to the greatest extent possible processing time.

Recommendation 6c: If a person at risk has been dealt with by the court and remanded in custody, arrangements will be made to transport that person as soon as possible to custody in the remand centre, or if appropriate to hospital. In other words priority will be given to such people and their transport will be organised separately if necessary. It is noted in accordance with Recommendation 4 that a fitness to travel assessment may be required at this stage from MH.

Recommendation 7*: How information concerning self harm is to be communicated to the court

The magistrates should consider this issue and issue guidelines or directions upon it. The round table group recognises that the issue of potential self harm will be relevant to both the question of bail, and the issue of whether the court needs to make any special orders as to the care of the person in custody.

* Note that the ACT Courts Administration does not join in these recommendations as they relate to the operation of the courts.

ROUND TABLE GROUP – ISSUE OF HOW INFORMATION CONCERNING SELF HARM IS TO BE COMMUNICATED TO THE COURT

The Round Table Group
The round table group brings together the following agencies and bodies:

Australian Federal Police ("AFP");
ACT Corrective Services ("ACTCS");
Mental Health ACT ("MH"); and
ACT Courts Administration.

The round table is facilitated by the Director of Public Prosecutions ("DPP").

Background to the issue
Information that a person is at risk of self harm is relevant to the magistrate before whom the person appears in respect of two matters:

- On the question of bail
- For the purposes of the court making any orders as to the care of the person in custody

The issue is how the information can be communicated to the magistrate hearing the matter.

Such information would not normally appear in the statement of facts.

Issues of medical privacy may potentially be involved.

If the recommendations of the Round Table Group are accepted, all persons at risk of self harm who are lodged in the court cells will all be assessed by Mental Health ACT ("MH").

MH would accordingly be in a position to give a report in respect of the person directly to the magistrate hearing the matter. This report could be oral, or possibly a short written report could be obtained. Such a report would be in the nature of a pre-sentence report, in other words a report made directly to the court and not tendered by one or other of the parties. Clearly the parties would have to be informed of the contents of the report.

The issues to be considered
The Round Table Group respectfully requests consideration of the following matters:

1. **How should the information that a person in custody is at risk of self harm be communicated to the court?**

2. **If the information is to be reported to the court by MH, what form should such a report take?**

Our Ref: NG:td **23908**

25 March 2009

The Coroner
ACT Coroner's Office
GPO Box 370
CANBERRA ACT 2601
FAX: 6205-9590

Dear Sir

INQUEST INTO THE DEATH OF TANIA PAULINE LIOULIOS
FURTHER COMMENT IN RELATION TO PROPOSED FINDING CONCERNING DIMITRIS LIOULIOS

I refer to the letter received from Michael Edwards dated 11 March 2009 inviting comment in respect of some of your draft findings. I am writing specifically in relation to paragraph 2, which appears on pages 1 and 2 of the Extracts section of the materials provided. This comment relates to Dimitris Lioulios' behaviour after his wife was released from the Canberra Hospital on the 3rd of July 2008. Broken down the comment is:

(a) That Mr Lioulios was aware of the conditions of his wife's release from Canberra Hospital;

(b) That he recognised the danger of her non adherence to them; and

(c) That in those circumstances he did nothing to ensure that she complied with those conditions apart from endeavouring to telephone her.

That comment follows an extract taken from the record of interview provided by Mr Lioulios and admitted into evidence as an exhibit.

Mr Lioulios provided a record of conversation with the AFP on the 5th of July 2008. A redacted or reduced version of that record of conversation was admitted into evidence. The section quoted on page 2 of the extracts section is part of the answer to question 200.

In that answer Mr Lioulios is outlining what happened on the night of 3 July 2008.

The events of 3 July 2008

Mr Lioulios has two daughters, Peta and Agape. On the 3rd of July 2008 Agape was in Greece waiting to meet her parents who were due to fly over the 5th of July 2008. Peta was in Canberra and was due to fly to Greece with her parents. Peta was 14 years old at that time.

In his record of conversation at paragraph 285 Mr Lioulios confirms that on the afternoon of 3 July 2008 he went to the Canberra Hospital to see his wife. He was told that the incident (the attempted suicide) wasn't life threatening but that his wife needed to be checked out. He took his daughter home.

Later that evening he received a call from Nurse Jenny Williams. Nurse Williams indicated that Tania didn't want to stay and asked if he could come and pick her up. Mr Lioulios was advised that she was okay to come home and instructed to bring some clothes with him.

Mr Lioulios attended the Canberra Hospital with some clothes for his wife and spoke with Nurse Williams.

Nurse Williams gave evidence before the Coroner and indicated that she had a conversation with both Mr and Mrs Lioulios. She formed the opinion that they were in a loving marriage. She advised Mr Lioulios that Mrs Lioulios was right to return home with him. At that time Mr Lioulios had no idea that his wife then intended to pick up her phone and her car or go to Deakin and write some reports.

Mr Lioulios went to the hospital, picked his wife up and took her home. Mrs Lioulios wanted to get her car and her phone so he took her to get her car from the Deakin office. Mrs Lioulios then drove to her sister's place to collect her phone.

Mr Lioulios left his wife at Deakin believing she was going to drive her car home after collecting her phone. He called to see where she was when she had not returned. She did not answer. She later called him and said she would stay at the office and write reports. Mr Lioulios confirms that he knew his wife had a lot of reports to do. He asked her to come home and do them from home.

His wife said:

"No, no. I'm going to have to do this work, you know. We're going on a flight. I'll work all night tonight."

Mr Lioulios says that he was trying not to pressure his wife. He states that his concern was that if he pressured her that may trigger her to do something irrational. He says that although he was concerned about her, it was not unusual for his wife to work long hours.

Katrina Lauro, Tania Lioulios' sister, participated in a record of conversation with the Australian Federal Police on the 10th of July 2008. She was not required for cross examination. A redacted version of that statement was admitted as an exhibit.

In the course of that statement Katrina Lauro indicates at question and answer sequence 108 and 132 that on the evening of 3 July 2008 her and her brother Marcus Chacos were at the hospital, as was Dimitris Lioulios. She says that she and her brother left the hospital at about 9 pm that evening. At that time Tania Lioulios was lying down, she was aware that they were there but she was engaging in minimal conversation. Dimitris had left earlier as he needed to get back to his daughter Peta.

Katrina Lauro confirms that she received a call from her sister at about 11 and that her sister then came to her house to collect her mobile phone that was in Katrina's possession. Tania Lioulios called on her sister Katrina Lauro at about 11.45 and collected her phone.

Katrina, who worked with her sister Tania Lioulios, confirmed that she did work excessive hours. At question and answer sequence 323 Katrina confirms that because they (Tania and Dimitris) were going overseas, Tania was trying to rap up a lot of work.

Katrina Lauro speaks about her sister Tania coming to see her to get the mobile phone at question and answer sequences 41, 42, 43 and 132. Nothing in the statements of Katrina Lauro indicates that Tania was behaving in an unusual manner when she called around to collect her phone, even though it was late at night.

The plan on the file at ACT Mental Health held at Canberra Hospital indicates that Tania Lioulios was released to go home with her husband and in the CATT Team was to DOM AM as per policy.

We know that Tania Lioulios did go home with her husband but then she left and collected her car and mobile phone before going around to Dr Veness' house.

We know that she told her husband that she was going to her office to do reports.

Nurse Jenny Williams gave evidence before the Coroner.

There was little or nothing in the evidence given by Nurse Williams to indicate that Mr Lioulios had been made aware of any conditions pertaining to his wife's release from the Canberra Hospital.

Indeed, it doesn't appear that it was until after she was released that Tania Lioulios decided that she needed to obtain both her car and her mobile phone.

At the time of Tania Lioulios' release from the Canberra Hospital on the 3rd of July 2008, all parties, Mr Lioulios, Jenny Williams and Tania Lioulios appeared to be in agreement that Mrs Lioulios would return home with her husband.

The contention that Mr Lioulios was aware of the conditions of his wife's' release

There is no evidence to indicate that Mr Lioulios recognised the danger of non adherence with the "conditions" of his wife's release.

His own evidence is that he was worried about his wife going into her Deakin office. He was also concerned that if he tried to dictate terms to her and refused to allow her to go to her office that she might do something irrational. He was placed in an extremely difficult position. Mr Lioulios had no power to restrain his wife's actions in any way.

It is reasonable for Mr Lioulios to have assumed that his wife was indeed going to her office to complete reports.

Mr Lioulios was aware of his wife's heavy workload and her strong work ethic. He was aware that she needed to complete a number of reports prior to their impending trip to Greece.

Mr Lioulios also had the care of his 14 year old daughter to consider. Someone needed to be home to look after her.

The contention that Mr Lioulios failed in some way to ensure his wife complied with the "conditions" of her release

Mr Lioulios attempted to persuade his wife to either get the car and mobile phone the next day or alternatively to bring her laptop home and work from home. There is little more he could have done.

There are no suggestions in the extract as to what action Mr Lioulios should or could have taken aside from trying to persuade his wife to remain at home.

Looking at potential actions:

(a) Mr Lioulios could have phoned the Police:

His wife had committed no crime. She had been released from the hospital after assessment by the CATT Team. She was to all intents and purposes free to do as she wished. The CATT Mental Health Plan indicated that Mr Lioulios should take his wife home. He did. There was no requirement that he restrict her liberty thereafter. There was no ability on his part to restrict her liberty.

The CATT Plan indicated that Mental Health would contact Mrs Lioulios the next day. As it turned out, that did not occur.

Surely, Mr Lioulios cannot be criticised for failing to contact the Police after his wife did not heed his requests to return home, or to remain at home and not to go out and get her car and mobile phone. The Police could not have intervened in any event.

(b) Mr Lioulios could have contacted the Mental Health Team at the Canberra Hospital:

It is submitted that this also would not have produced any change in circumstance. Mrs Lioulios was cleared by Nurse Jenny Williams and discharged from the Canberra Hospital in the company of her husband. There was no direction that she not leave his side until further assessment by the CATT team. Mr Lioulios could have reported to Nurse Williams that

his wife was no longer in his company and that she had told him she would be getting her car, mobile phone and going to her office to do reports. In the circumstances it appears extremely unlikely that Nurse Williams would then have taken any action at all.

None of these actions indicate irrational or aberrant behaviour. Mr Lioulios was not told and did not know until afterward that his wife was going to see Dr Veness. As far as he was aware his wife had an AVO against Dr Veness.

Nurse Williams went off shift shortly after Mrs Lioulios was released. Nurse Clare Bickmore then came on shift. Mrs Lioulios presented twice to Nurse Clare Bickmore in the company of Police having breached a Apprehended Violence Order taken out against her by Dr Veness in circumstances where she had previously been released from the Canberra Hospital after assessment by Nurse Williams.

If Nurse Bickmore was not prepared to admit Mrs Lioulios in those circumstances, it seems extremely unlikely that she would have admitted Mrs Lioulios on the bald assertion from her husband that she was not at home with him and had instead chosen to go to her office to write some reports.

Conclusion

In summary it is submitted on behalf of Mr Lioulios that there is little he could have done aside from that which he did do to ensure his wife complied with the conditions of her release; namely that she return home with him.

Mr Lioulios brought his wife home. He had no power to restrain her or keep her captive in their own house.

He was not made aware of any conditions applying to her release from the Canberra Hospital, nor was he informed of any apparent dangers arising from any failure on the part of Mrs Lioulios to spend the evening at home with him.

Even if Mr Lioulios had been appraised of conditions associated with Mrs Lioulios' discharge on the 3rd of July 2008 and informed of the need to keep her at home with him due to perceived dangers associated with her leaving his company, there was little he could have done to prevent her from going.

Had Mr Lioulios refused to drive his wife, should could no doubt have caught a taxi.

Had Mr Lioulios phoned the Police, they could not have assisted him as no crime had been committed.

If Mr Lioulios had contacted the Mental Health Team at the Canberra Hospital, it is extremely unlikely that they would have been either able or inclined to assist.

In circumstances where the CATT Team member Nurse Bickmore did not admit Mrs Lioulios when she presented in the company of Police Officers following a criminal offence, it is highly unlikely if not inherently improbable that the CATT Team would have done anything different had Mr Lioulios phoned them and told them that his wife was no longer with him; particularly in circumstances where his wife had provided a perfectly acceptable explanation as to where she was going and why.

I thank you for the opportunity to provide further comment on behalf of Mr Lioulios and would appreciate it if you could take the matters raised in this letter into account in making your final findings in respect of this matter.

On behalf of the family I would like to thank you for the promptness with which you have undertaken your inquiry into the death of the late Dr Tania Pauline Lioulios.

Yours faithfully

pappas, j. – attorney

Nigel Gabbedy
Direct Line: 6261 6511
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IN THE CORONERS COURT
AT CANBERRA IN THE
AUSTRALIAN CAPITAL TERRITORY

NO CD715 OF 2008

INQUEST INTO THE DEATH OF

TANIA LIOULIOS

Submissions of the Commissioner of the Australian Federal Police in response to proposed adverse comment

Introduction

1. The Commissioner of the Australian Federal Police (the Commissioner) makes these submissions, pursuant to s 55(1)(a) of the *Coroners' Act 1997*. On 11 March 2009 the Court provided a copy of the proposed comments and recommendations and these submissions are made in response to some aspects of those proposed comments and findings which are relevant to the Australian Federal Police (the AFP). The Commissioner makes these submissions notwithstanding the view that because the matters commented upon are not causal, it is not part of the Coroner's function to provide formal comment upon them.

Comments page 2, numbered paragraph 1

2. It is proposed to comment that the BART file did not contain a photograph of the detainee by Watch House staff. It is respectfully submitted that this paragraph should be deleted.

3. Firstly, the Commissioner submits, respectfully, that the evidence does not show that there was no photograph. Evidence was given by Sergeant Horrocks that he thought the photograph looked like a Corrective Services photograph (T376.44). Sergeant Horrocks went on to give evidence that the handwriting on the photograph was his (T377.5) and that he had compiled the BART file including the photograph (T384.35 onwards).

4. Other than this there was no evidence about how the photograph came to be on the BART file. The name used on the photograph was 'Chacos' (Ex 30). Perhaps this indicates that it was in the AFP's possession due to Mrs Lioulios' previous contact with the AFP, which gave rise to the use of the name 'Chacos' (see generally the evidence given by Constable Hockings). However, there was no suggestion during

Filed on behalf of the Australian Federal Police Commissioner by:

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proceedings that the existence or otherwise of the photograph, or its source, could impact in any way on the issues surrounding Mrs Lioulios' death and the issue was therefore not explored in great detail in examination of the witnesses.

5. Second, it is submitted that there is no requirement for the photograph on the BART file originate from the AFP (see Watch House Operations Manual Ex AL, para 6.8 at page 82). A photograph would perform the function of identifying a person regardless of its source. In short, it is submitted that in this context the source of the photograph is not an issue of 'public health and safety'.

Comments page 3, numbered paragraph 3

6. It is proposed to comment that the clinical notes of Mrs Bickmore should have been included in the BART file. It is respectfully submitted that this paragraph be deleted. Two matters are proposed to be raised. First, that the notes were relied upon by Sergeant Shakeshaft to justify the detention of Mrs Lioulios, and second, that it cannot be accepted that Sergeant Horrocks did not include the notes because he believed Mrs Lioulios was not suicidal.

7. It is respectfully submitted that the evidence does not establish that Sergeant Shakeshaft relied upon the notes to justify detention of Mrs Lioulios. Mrs Lioulios was initially detained for breaching a protection order. Her attendance at Canberra Hospital was as a result of concerns Sergeant Shakeshaft held independently of any medical assessment and it is noted that the clinical notes were not provided until after the second visit to Canberra Hospital. The clinical notes stated that Mrs Lioulios 'denied any intention to suicide' and that she had 'repeated that she was not suicidal at this time'. Following the second visit, Mrs Bickmore wrote:

> Mrs Lioulios has again assured me that she is not going to harm herself in the Watch House ...

That note was provided to police in the context of Mrs Lioulios being returned to police custody because the CAT team did not have concerns about her suicide risk (Ex R).

It is submitted that the clinical notes in themselves do not add information which would assist in assessing the risk. It did not contain information about prior suicide attempts. In fact, had they been included, it could reasonably have been concluded by a reader that the risk of suicide was low because a medical professional had noted that Mrs Lioulios denied any intention to suicide. Including the note could well have had the opposite effect to that which the proposed comment implies it could have had.

The important information, it is submitted, is that the AFP were concerned enough to convey Mrs Lioulios to Canberra Hospital on two occasions. The AFP should have provided that information, perhaps by including it in the prisoner history in the BART file. This is dealt with in the comments at page 4 numbered paragraph 4 and 5.

Page 4, paragraph 6 and third last paragraph

8. It is proposed to comment that there was no proper briefing of the Court Transport Unit and that the Corrective's officer should have been advised of the prisoner's sustained threats of suicide. It is submitted that it should be accepted that Constable Lane in fact briefed the Corrective Services staff that the AFP had been maintaining 15 minute checks on Ms Chacos and that she had threatened suicide. However, it may also be accepted that the Corrective Services staff left the City Watchhouse with the impression that they had been briefed that Mrs Lioulios had been noisy and rowdy throughout the night and had finally fallen asleep.

9. Thus the operative issue is that the briefing was not effective. That is a matter which has been addressed by the parties. It is submitted that the word 'proper' be amended to 'effective'.

10. Finally, it is noted that this issue is revisited in the proposed third last paragraph of page 4 of the comments. The court may wish to incorporate this paragraph as part of numbered paragraph 6.

25 March 2009

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Steve Webber
Solicitor for the
Commissioner of the
Australian Federal Police

IN THE CORONERS COURT
AT CANBERRA IN THE
AUSTRALIAN CAPITAL TERRITORY

AUSTRALIAN CAPITAL TERRITORY'S STATEMENT IN RESPONSE TO THE CORONER'S COMMENTS AND RECOMMENDATIONS PURSUANT TO PARAGRAPH 55 (1) (b) OF THE *CORONER'S ACT 1997* (ACT)

The Coroner has provided to the Australian Capital Territory, pursuant to section 55 of the *Coroners Act 1997* ("the Act"), the comments and recommendations proposed to be made in the Coroner's findings. Those comments and recommendations comprise excised portions of the Coroner's proposed findings and are divided into sections entitled "extracts" "comments" and "recommendations of the round table group". The Territory makes the following submissions on findings and comments directed to the Territory and its employees pursuant to paragraph 55 (1) (b) of the *Coroner's Act 1997* and requests pursuant to subsection 55 (3) of the Act that the Coroner include the written statement provided by the Territory in his report.

Extracts

1. The Territory notes the comments in section 1 of the "extracts" in relation to two employees of the Territory declining to participate in a taped interview with the Australian Federal Police officers investigating Ms Lioulios' death. The Territory submits that this is not a matter for a Coroner's findings or comments in an inquest. The scope of the Coroner's findings and comments is limited as set out in section 54 of the Act. The Territory submits that any comments about a witness lawfully declining to participate in an interview with the police cannot be characterised as "a matter connected with the death … including public health or safety or the administration of justice" and as such falls outside the scope of any comment the Coroner may make. There is no legal obligation which requires any witness to agree to be interviewed by the police officers investigating a person's death on behalf of the Coroner, or indeed to provide a statement to the Coroner in

respect of any coronial investigation. Each potential witness, including any Territory employee, has the right to decline to be interviewed by police officers or to provide a statement for the Coroner in the absence of a subpoena. No adverse inference may be drawn from any witness' refusal to be interviewed or provide a statement. The Territory and its legal representative could not, and did not, seek to coerce or influence any Territory employee in this regard.

2. In relation to section 3 of the "extracts" the Territory submits that any finding or comment that Ms Bickmore's assessment of Ms Lioulios was "flawed" is not open to the Coroner on the evidence. There was no medical evidence before the Coroner to call into question the assessment made by Nurse Bickmore. The fact that Ms Lioulios' subsequently died as a result of an injury caused by her own hand does not entitle the Coroner to make a finding that the assessment was inadequate or unreasonable in the absence of independent medical evidence in support of that proposition. On the contrary, the only medical evidence before the Coroner is the unchallenged evidence of Bruno Aloisi, a mental health professional who was employed by Mental Health ACT as the team leader of the Crisis Assessment Treatment Team. Mr Aloisi was asked to review the assessment by Nurse Bickmore. His evidence that "*the clinical decisions made by CATT members seemed to be reasonably appropriate judgments"* supports a finding that the assessments were reasonable and appropriate in the circumstances. The fact that Ms Lioulios' subsequently self harmed does not, in the absence of expert medical evidence, prove that the assessments were inadequate or "flawed".

3. In response to the matters influencing the Coroner's comments on this, the Territory notes:

   (a) In relation to the Coroner's comment about Ms Lioulios' "resolute attempt to take her own life" Ms Bickmore's evidence was that Ms Lioulios denied any intention to suicide stating "*she would go to prison first and then she will kill herself" (Ex Q)* She repeated "*she was not suicidal at the present time*" (time of first assessment). It is submitted that it is clearly a matter for expert medical opinion whether those comments were appropriately considered by Ms Bickmore, and whether appropriate action was taken in relation to them.

The Territory submits that in the absence of any medical evidence on this issue any reliance on these comments by Ms Lioulios as a factor demonstrating that Ms Bickmore's assessment of her was "flawed" is not open on the evidence.

(b) In relation to the Coroner's comments about Ms Modderman, the Territory notes that Ms Bickmore denied that Ms Modderman approached her regarding releasing Ms Lioulios into police custody saying she did not know Ms Modderman and would not have made the remarks attributed to her.

(c) Additionally, Ms Modderman was a triage nurse and did not hold any special qualification in mental health, as Ms Bickmore did. The Territory submits that it would have been inappropriate for an experienced mental health nurse to rely on the opinion of a nurse with no specialist mental health qualifications or experience above her own opinion.

(d) In relation to the Coroner's comments about inquiry into the reasons why Ms Lioulios had not been accepted into the City Watch House, the Territory notes that Ms Bickmore was not told that Constable Hockings or Sergeant Shakeshaft had considered that emergency action under the *Mental Health (Treatment and Care) Act 1994* was appropriate for Ms Lioulios, nor was any request made to take such emergency action in relation to Ms Lioulios. Ms Bickmore formed the view that Ms Lioulios' return on the second occasion was because she was "*becoming drowsy due to medication and alcohol taken earlier"* (Ex P). Ms Lioulios was medically assessed by Nurse Wootton and again recorded 15 on the Glasgow Coma Scale. There was no medical basis to admit Ms Lioulios to hospital. Ms Bickmore was advised by Constable Hockings (Ex V paragraph 9) "*we've been told to bring her back because our Sergeant isn't happy*." No further explanation was provided to Ms Bickmore as to why Ms Lioulios had been returned to the Canberra Hospital.

(e) In relation to the Coroner's comment about the failure to consider that Ms Lioulios might be released from custody, Ms Bickmore conceded she had not

considered that Ms Lioulios may be bailed from the Watch House or by the Magistrate.

(f) In relation to the Coroner's comment that "whatever the patient told the assessing nurse was accepted at face value", the Territory submits that Ms Bickmore's evidence was not that she simply accepted what Ms Lioulios told her without critically assessing it. Her evidence was that she assessed Ms Lioulios' comments in the context of all the information available to her at the time, including her demeanour, her body language and the history she had been provided. The Territory submits that it is appropriate that Ms Bickmore made a judgment about whether her patient was being truthful based on those factors in light of her own training and experience in assessing patients over a twenty year period.

(g) In relation to the Coroner's comment about inquiries into Ms Lioulios' previous self-harm attempt, the Territory notes that, having regard to her training and experience, it was not Ms Bickmore's practice to make detailed inquiries about previous suicide attempts. There is no independent medical evidence before the Coroner to suggest that it would have been prudent or appropriate to make such inquiries, or that to do so would have made any difference to the assessment.

(h) In relation to the Coroner's comments about contact with the Court Liaison Officer, the Territory notes that Ms Bickmore maintained her position that, in her clinical opinion at the time, Ms Lioulios was not likely to self harm in the immediate future and she would be safe in the custody of police (T/S p.317) however she conceded that she should have sent an email to the Court Liaison Officer regarding Ms Lioulios' presentations.

4. In relation to section 4 of the "extracts" the Territory notes the Coroner's recommendation that where a person in custody presents for a mental health assessment more than once in a 24 hour period the patient must be seen by a psychiatric registrar.

Comments

5. It is noted that agencies of the Territory, namely ACT Corrective Services and Mental Health ACT, participated in the round table group convened by the ACT Director of Public Prosecutions and participated in the formulation of the 7 recommendations made by the group.

6. In relation to the Coroner's comment about the failure of a member of the Mental Health ACT Crisis, Assessment and Treatment Team to notify the Mental Health ACT's Court Liaison Officer that Ms Lioulios was scheduled to be brought before the Court on 4 July 2008, the Territory accepts that such notification should have taken place. The Territory notes the Coroner's comments about Mental Health ACT's record-keeping.

7. In relation to the Coroner's comments that the role of the Court Liaison Officer should be brought to the attention of, among other groups, members of ACT Corrective Services the Territory adopts this recommendation and notes that significant steps to carry out this recommendation have already taken place.

8. The Coroner's has made the comment that "the conduct of [ACT Corrective Services] officers … [was] was deviant from that standard of care expected for the protection and safekeeping of a person exhibiting significant mental difficulties". The Territory submits that the issue of the standard of care expected of Corrective Services Officers is not a matter for the Coroner, and to comment on any potential civil liability is inappropriate and beyond the scope of the Coroner's task. In *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 (5 August 2005) Higgins CJ, Crispin and Bennett JJ stated at [12]:

The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another **or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant section of the *Coroners Act 1997* ("the Act") and make, if possible, the required findings and any comments that may be appropriate [emphasis added]..**

The issue of the standard of care expected of a corrective services officer is an element of negligence, and given that a determination of civil liability does not fall within the task of the Coroner, the Territory submits that any finding or comment on the standard of care expected of a Corrective Services Officer is not a consideration for the Coroner.

9. In relation to the reasons the Coroner gives for making the comments about the , actions of the Corrective Services Officers, the Territory notes:

(a) The Bart file was not marked with "Depression" by the AFP (which would, according to the AFP's policy, indicate that a prisoner was at risk of self harm) though the file was stamped "*Prisoner At Risk*." It was unclear why the stamp Prisoner At Risk was applied given that A/Sgt Horrocks concluded Ms Lioulios was not suicidal (T/Sp.375 ln1 -2). The AFP did not provide any information to ACT Corrective Services regarding Ms Lioulios' previous admission to the Canberra Hospital in relation to a suicide attempt on 3rd July nor any information about the two subsequent presentations to ACT Mental Health on 4th July 2008 of which they were aware nor did the AFP enclose the report by ACT Mental Health provided by Ms Bickmore.

(b) There was no oral handover regarding the concerns held by AFP officers about Ms Lioulios' mental health. Both the Watch House Operations Manual (Ex AL Section 2.14) and the MOU between ACTCS and the AFP relating to Prisoner Transfer (Ex AJ Sections 4 and 8) emphasize the importance of providing those responsible for the safe custody of prisoners with information regarding the circumstances resulting in the detainee being in police custody and their behaviour at the time of the arrest including the prisoner's demeanour, behaviour and medical status. This was not done. ACT

Corrective Services officers were not aware that Ms Lioulios had been "*exhibiting significant mental difficulties*" when she was placed in their care, though it is clear that AFP officers were aware of this fact.

(c) Regarding the presence of ACT Corrective Services Officers during bail proceedings, only one officer observed Ms Lioulios. She had no training whatsoever in assessing whether an individual was displaying "*suicidal ideation*" nor would her opinion be given any weight in the absence of medical qualifications. The Territory submits that it is beyond the scope of the duties of a Corrective Services Officer in court or at the bail office to make any determination about whether a prisoner is displaying suicidal ideation. It is the duty of custodial officers in court to ensure the security and safety of the court and the prisoner, not to conduct mental health assessments on prisoners. The Corrective Services Officer properly conveyed to her supervisor that Ms Lioulios had been marked a "Prisoner At Risk" by the Magistrate.

(d) It is noted that Ms Lioulios advised the Induction Officer that she had attempted to self harm the previous day however when pressed she refused to provide any further specific information about this.

(e) It is noted that Ms Lioulios was removed from the cell she shared with another prisoner, however, according to officers present her behaviour was not unusual amongst detainees and was against a background where her behaviour had not been unusual or disruptive, and she had been compliant for about 6 hours. Removing her to the padded cell was done for abundant caution and it is submitted that doing so cannot be said to be evidence of some dereliction of duty.

(f) It is accepted that Ms Lioulios' goading utterances were provocative. However the Territory submits that such behaviour should not be presumed to be "uncharacteristic". On the contrary, the evidence before the Coroner indicates that her conduct and her goading of officers was not uncharacteristic behaviour for detainees. As this was the first time Ms

Lioulios was in custody in the court cells, the officers were not in a position to assess whether her behaviour was uncharacteristic for her personally.

(g) The Coroner's comments that Ms Lioulios "undertook behaviour that can only be described as attempting self harm". The Territory submits that that is not the only way that her behaviour can be described, and it should not be so described. Indeed, almost all of the custodial officers who appeared before the Coroner gave evidence that they did not think her behaviour constituted attempts at self-harm, including all the more experienced officers. Those officers' experiences in dealing with distressed, upset, angry, violent, non-compliant and provocative prisoners should not be dismissed, particularly as it was their evidence that such behaviour was not uncharacteristic for prisoners. What may appear unusual behaviour to a lay person was, on the evidence of most of the custodial officers, not unusual in the context of the custodial environment. It may be that with the wisdom of hindsight an analysis of Ms Lioulios' conduct from the time she was brought down from the Magistrates Court until she was transported to the Belconnen Remand Centre can be viewed in a different light. However it should be noted that Ms Lioulios' was seen by the Magistrate at 9.30 a.m. and then remained compliant for a further 4 and half hours. She became non compliant in the cells following a strip search (which was presumably traumatic for her but in accordance with Standing Orders at the time). She then became distressed and commenced banging her head on the cell wall, but she remained responsive to directions to stop. She became non-compliant and abusive when being removed to the padded cell. It was against this background that individual officers observed her aberrant behaviour (removing the under wire from her bra etc) interspersed with performing their other duties. Although the induction form records the previous attempt at self harm, there is no evidence that officers Tracey, Cannon, Thackeray or Dew were aware of any previous attempt to self harm or her admission to the Canberra Hospital on 3rd July or subsequent presentations. Additionally, none of the custodial officers had any training in psychiatry or psychology nor were they expected to have such training. It is unfair and outside their area of training and

expertise to require individual custodial officers to have determined that Ms Lioulios was "*psychiatrically ill"* whilst in their care.

(h) The Coroner also accepted that each piece of individual conduct by Ms Lioulios might be described as non-compliant, but his Honour was unable to accept that "any responsible officer apprised of the totality of the prisoner's conduct could so describe it" and that "from time to time prisoners exhibit various aspects of that conduct but not in total". The Territory submits that there is no evidence to support this conclusion that prisoners do not exhibit conduct similar to the totality of Ms Lioulios' conduct. On the contrary, the evidence before the Coroner was that Ms Lioulios's behaviour was not uncharacteristic for prisoners. It is for precisely this reason that all but the least experienced officer who appeared before the Coroner gave evidence that he or she did not characterise Ms Lioulios' behaviour as genuine attempts at self-harm, but rather as non-compliance. There was no evidence from any other source about what is characteristic behaviour for a prisoner which could be capable to undermining the overwhelming evidence of the custodial officers.

(i) There was little or no delay from the time Ms Lioulios displayed aberrant behaviour (removing her bra etc) and transporting her to the Belconnen Remand Centre. She was conveyed only minutes after the display of this behaviour to a facility where she would receive a full psychiatric assessment. Mr Cannon (CO2 working in the Court Transport Unit (CTU) on 4th July 2008) said in evidence that "*mental health assessments do not take place in the cells, though they had a couple of years ago, the (mental health officer) does not speak with prisoners unless ordered by the Magistrate to go down and see them*." (T/S p.499 ln 34 – p.500 ln 15) He agreed that there were no lines of communication with the CLO on 4th July 2008 such that he could request their attendance at the cells however there are now lines of communication. (T/S p.503 ln 40 – p.504 ln 1) Ms West indicated that the CLO was available to the CTU however other than preliminary training given as part of the Certificate 1 in Custodial Operations no other training had been given to the CTU regarding access to the service provided by the CLO.

(j) The Territory submits that Standing Order 20, which was in force at the time, but is no longer in force, is ambiguous. It refers to "*procedures to be followed in the event of a prisoner being deemed as a Prisoner at Risk (PAR) and in the event of threatened or actual self harm*." There is no definition as to what constitutes "*threatened self harm" or "actual self harm."* Order 20.7.1 sets out the procedures to be taken in the event of "*attempted suicide/actual self harm*." It is clear that an actual suicide attempt or self harm incident is considered to be an incident that required immediate medical intervention i.e. (a) provide First Aid Treatment; (b) notify the Manager CTU; and 20.7.2 (a) Contact the Ambulance Service (if required); (b) contact CATT (if required); (c) prevent further suicide or self harm attempts by removing dangerous articles from the prisoner etc.

(k) Order 20.2.3 states that "*all incidents of suicide/attempted suicide are deemed Mandatory Notifiable Incidents…..(however) The notification to the Director of an incident of self-harm by a prisoner is discretionary, according to the gravity of the incident and as directed by the Superintendent*." There was no incident of self harm requiring immediate medical intervention and it may be inferred that more senior officers took the view that a report or reclassification was only required on an occasion of actual self harm or a serious attempt at suicide. It is noted that only the least experienced officer construed Ms Lioulios' behaviour as an attempted suicide. Ms Lioulios' was not reclassified.

(l) Under section 8 of the *Remand Centres Act 1976*, the administrator was empowered to make standing orders necessary for the day-to-day running of remand centres. Standing Order 20 was made pursuant to this provision. The *Remand Centres Act 1976* was repealed by the S*entencing Legislation Amendment Act 2006* on 3 June 2006, as were any registrable instruments made under the *Remand Centres Act*. The *Corrections Management Act 2007* had come into force by 4th July 2008 and effectively replaced the *Remand Centres Act 1976*. Following the introduction of the *Corrections Management Act,* ACT Corrective Services undertook a review of all policies and procedures. On 4th July 2008 there was no policy to replace Standing

Order 20. Since 4th July 2008 Corrective Services have introduced the Prisoner At Risk Management and Escort Procedure pursuant to section 14 of the *Corrections Management Act 2007* in addition to a number of related procedures referred to by the Coroner.

(m) In relation to the Coroner's comments about the vehicle used to transport Ms Lioulios to the Belconnen remand Centre, the Territory accepts that the vehicle, a Toyota Hi-Ace (Romeo 3), was not fitted with a camera and proved to be unsuitable. The Territory notes, however, that there had been no previous self-harm incident in relation to any of the custodial transport vehicles in use at the time. All vehicles have now been fitted with CCTV, lighting and intercom systems, and any prisoner being transported is under 5 minute observations by the escort officer in the vehicle. Prisoners identified as being "At Risk" are now transported in Romeo 5, which is a station wagon. They are placed in the back seat in the middle with an officer on either side of them.

10. The Territory notes the comments of the Coroner regarding ACT Corrective Services changes to the policies and procedures of the Court Transport Unit.

11. The Territory notes the recommendation of the Coroner that:

(a) the attending AFP officer be required to sign the Prisoner Alert Sheet;
(b) persons whose files are marked Prisoner At Risk be afforded access to the Court Liaison Officer as soon as practicable after handover from the AFP to the CTU; and
(c) priority be given to the removal of a prisoner at risk from the court cells to the Belconnen Remand Centre or to some other facitlity for the assessment and/or treatment of the prisoner.

Amanda Tonkin
Counsel for the Territory

23rd March 2009